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ABSTRACT

These 12 monthly issues from 1999 explore problems encountered by children and adolescents. Regular features include "Keep Your Eye On...," brief accounts of research into childhood and adolescent problems; "What's New in Research," summarizing research from recent publications and professional conferences; "Commentary," editorials from professionals working with children and adolescents; "Announcements," events and conferences of interest; book reviews; and client handouts for use by practitioners. Major topics include: (1) pedophilia, character education, and asthma (January); (2) Attention Deficit Hyperactivity Disorder (ADHD) drug treatment, public policy, Tourette Syndrome, and head trauma (February); (3) changes in family life between 1981 and 1997, adolescent male sex offenders, ADHD diagnosis, and premature infants' behavior and sensory problems (March); (4) boys' violent behavior, clonidine toxicity in children with ADHD, and childhood behavior disorders (April); (5) autism and childhood schizophrenia, and persistence of girls' antisocial behavior (May); (6) achievement and motivation in poor/minority children, autism and childhood schizophrenia, and solvent exposure risks in pregnancy (June); (7) anger, assertiveness training, maternal smoking and criminal behavior, and gang membership (July); (8) violence prevention programs, teen pregnancy and STD rates, firearms, and spanking (August); (9) cheating in school, school discipline, and child behavior checklists for assessment (September); (10) Girls Choir of Harlem to assist in transition to adulthood, and connections between

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industrial/organizational psychology and developmental psychology (October); (11) standardized checklists and contextual determinants of behavior, and infants' musical perception (November); and (12) sexual identity and homosexual adjustment issues in counseling, and early experience and brain development (December). (KB)

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

PS 02819 1

Sex Crimes

Fear of homosexuals in schools is based on myth

By Mary Ann Sorrentino

The witch hunters have been hunting the wrong witches. Despite consistent research findings that show no particular connection between pedophilia and homosexuality, too many parents and other adults fear the involvement of homosexuals in our educational system. They express outrage and terror that gay men and lesbian women are allowed to teach their children, coach them on the ball field, accompany them on the class trip. They say they do not want their children to be exposed to "that lifestyle," convinced that gay individuals might "teach" gayness — as if anyone would wish the torment of a closeted, persecuted existence on any child, or wish them to be "guilty until proven innocent."

> ***Studies have consistently shown that pedophiles are not gay men and lesbian women most of the time, but heterosexual, usually impotent, generally married adults, often with children of their own.***

Last year, in southeastern Massachusetts, a coach was accused, and later found guilty of, sexually abusing young women in his charge. At first, cries of "Rape!" went unheeded, by town school officials and others. Defenders recalled that the coach was an institution at the high school where he taught. He couldn't possibly have done these terrible things, they chorused. He wasn't gay, wasn't a pervert. He was, they assured us, "a family man."

They were wrong, of course. Today he sits in prison, serving a too short sentence for a

(turn to 5)

Vol. 15, No. 1 January 1999

Inside This Issue

Asthmatic symptoms reported differently.
See page 3

Brain abnormalities in childhood schizophrenia.
See page 4

Commentary: Defining moments are important influences on developmental destinies.
See page 8

This month's client handout:
What to do when your child is a bully

Character Education

Program produces S.T.A.R. pupils

By Susan Farley

A program that encourages children to develop values is being integrated into the curriculum and activities of public and private schools, YMCA's, the Boys and Girls Clubs of America, various organizations including churches and martial arts schools.

The Jefferson Center for Character Education in Monrovia, Calif., a non-profit organization, created the S.T.A.R program, an acronym for its method, "Stop, Think, Act and Review" for younger children and "Success Through Accepting Responsibility" for adolescents.

The S.T.A.R. program stresses honesty, respect, responsibility, integrity, courage, tolerance, justice, self-confidence and politeness. According to Robert Jamieson, president, CEO and project manager of The Jefferson Center, "[The program] inculcates these values and turns them into words kids can understand, like 'responsibility.' We keep it as simple and as basic as we possibly can."

Monthly themes

Tammi Rainville is a S.T.A.R. program coordinator at Limerick Elementary School in Canoga Park, Calif., which has been using the program for seven years as a part of

(turn to 6)

The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

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Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

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Keep Your Eye On

... childhood poverty and Alzheimer's disease.

A study from the University of South Florida (USF) in Tampa indicates that poverty and poor education in childhood can greatly increase the risk of Alzheimer's disease in later life. The chance of having Alzheimer's disease was five to 11 times higher in adults who had a family history of the illness and who experienced poverty in childhood or were poorly educated. Neither poverty nor low education influenced the risk of getting Alzheimer's disease in people who came from families where none of their siblings had the disease. The combination of a family history of the disease and childhood poverty led to a very high risk of Alzheimer's — those people were 30 times more likely to have Alzheimer's disease in late life compared to people without a family history of the illness who grew up in families unaffected by poverty. "We may be able to prevent a large number of cases [of Alzheimer's] through improved nutrition and better education in childhood when the brain is developing to its adult size," says James A. Mortimer, Ph.D., director of the USF Institute on Aging and lead author of the report. The findings were based on a study of 122 people with Alzheimer's disease and 279 people without the disease who were of similar age and sex. The data were presented at the Sixth International Conference on Alzheimer's Disease and Related Disorders, held recently in Amsterdam. (For more information, contact Michael Hoad, USF Health Sciences Public Affairs, MDC 47, 12901 Bruce D. Downs Blvd., Tampa, FL 33612-4799; (813) 974-3300.)

... substance abuse risks.

A review of the latest studies on risk and protective factors for the development of substance abuse in children indicates that behavioral, emotional and environmental factors do play a key role in their decision to use drugs. Factors that were related to alcohol, drug or tobacco use during adolescence included poor self-image, lack of religious belief, poor school performance, parental rejection, family dysfunction, parental abuse and divorce.

Protective factors included growing up in a nurturing home, having committed teachers, academic achievement and learning positive self-esteem and assertiveness skills. Those factors instill resiliency in youth, the review concludes, and allows them to overcome negative life circumstances and avoid novelty-seeking behaviors.

The authors recommend that prevention programs aimed at youth who are at risk for substance abuse should be age-appropriate, research-based, culturally relevant and interactive. Further research is needed to develop alcohol and drug prevention programs that will have effects that are sustained throughout a child's youth.

To obtain a reprint of the review, which was published in the October 1998 issue of the *Archives of Pediatrics and Adolescent*

Medicine, contact Harolyn M.E. Belcher, M.D., The Kennedy Krieger Institute, 707 N. Broadway, Baltimore, MD 21205; or e-mail belcher@kennedykrieger.com.

... sexual abuse in boys.

In an analysis of 166 studies published from 1985 to 1997 on the sexual abuse of boys, University of Pennsylvania researchers found that boys at highest risk were younger than 13 years old, nonwhite, of low socioeconomic status and not living with their fathers. Perpetrators tended to be known but unrelated males. Abuse frequently occurred outside the home, involved sexual penetration and occurred more than once. The sequelae associated with the abuse included psychological distress, substance abuse and sexually related problems.

Researchers report that the sexual abuse of boys "appears to be common, under reported, under recognized and under treated." (*Journal of the American Medical Association*, December 2, 1998.) For more information, contact Gail B. Slap, M.D., M.S., Adolescent Medicine, The Children's Hospital of Philadelphia, 34th Street and Civic Center Blvd., Philadelphia, PA 19104.

What's New in Research

Garlic has no effect on children's cholesterol

Recent research indicates that garlic extract therapy has no significant effect on cardiovascular risk factors in pediatric patients with familial hyperlipidemia.

Researchers conducted a randomized, double-blind, placebo-controlled study of 30 pediatric patients ages eight to 18 years old with familial hyperlipidemia to determine if garlic extract would lower their cholesterol. After receiving an eight-week course of 300 mg of commercially available garlic extract (Kwai, manufactured by Lichtwer Pharma in Berlin, Germany) three times daily or placebo, the children's fasting lipid levels were evaluated.

The treated and untreated groups were equivalent at baseline and compliance was similar in both groups. There was no significant relative attributable effect of garlic extract on fasting total cholesterol levels or low-density lipoprotein (LDL) cholesterol levels. In addition, there was no significant effect found on the levels of high-density lipoprotein (HDL) levels, triglyceride levels, apolipoproteins B-100, lipoprotein(a), fibrinogen, homocysteine or blood pressure. However, there was a small effect on apolipoprotein A-I. No differences in adverse effects were found between the two groups of patients.

McCrindle BW, Helden E, Conner WT: Garlic extract therapy in children with hypercholesteremia. *Archives of Pediatrics and Adolescent Medicine* 1998; 152:1089-1094. For reprints, contact Brian W. McCrindle, M.D., M.P.H., F.R.C.P.C., The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, Canada M5G 1X8.

Resources

Two-part series addresses conflict resolution

Pyramid Video in Santa Monica, Calif., has a two-part video series available on conflict resolution for students. The series is designed to open discussion on the issue of school violence with techniques necessary to prevent angry confrontations and replace them with peaceful solutions. The series was produced by the Seattle Public Schools Instructional Broadcast Center. Each part presents two vignettes that demonstrate a confrontation, followed by interviews with participants, who give their initial responses to the conflict. At the end of each vignette, participants are urged to discuss it with a segment titled "Thinking It Over," which encourages them to rethink angry responses.

Part one, "Student-to-Student Conflict" contains sections on peer pressure and interpersonal communication. Part two, "Student-to-Adult Conflict," depicts a heated argument between a teenager and her teacher; it also contains a segment on a store owner who mistakenly accuses a group of students of stealing from him.

Review videos and photos are available. Costs range from $195 to $295 for each series, which includes a study guide. For more information, contact Pyramid Video, P.O. Box 1048, Santa Monica, CA, 90406-1048; phone (310) 828-7577.

Asthmatic symptoms reported differently

Clinicians and researchers evaluating asthma morbidity in children should elicit child reports of symptoms in addition to parents' reports, say the authors of recently published research.

The researchers conducted a

study of predominantly Latino children with asthma who were six to 18 years old, to determine if parent and child reports of asthma symptoms with exercise differed and to evaluate the validity of child and parent reports of symptoms.

Data were obtained from child and parent interviews, pulmonary function tests and observation of symptoms after exercise. The study took place at three summer camps for minority children with asthma in Los Angeles County.

Ninety-seven children with asthma were evaluated — 78 percent were Latino, 12 percent were white and 9 percent were other minorities. Investigators noted child and parent reports of cough and wheezing with exercise and performed pulmonary function tests before and after exercise.

Eighteen percent of children reported never having a cough when they exercised, and 46 percent reported having a cough occasionally when they exercised and 36 percent reported having it quite often or always. For wheezing, 20 percent of children reported never wheezing when they exercised compared to 35 percent who had it occasionally and 45 percent having it quite often or always. Pulmonary function tests correlated with those reports, with 47 percent of children having reductions in pulmonary function such as peak expiratory flow rates.

Parents reported fewer symptoms than did their children, with 34 percent reporting that their children did not have cough with exercise, 37 percent reporting coughing occurred on few to some days, and 29 percent reporting that it occurred most days or every day. Forty-seven percent of parents reported that their children did not wheeze with exercise in the last two months, 35 percent reported wheezing on a few days to some days, and 17 percent reported wheezing most days to every day.

The researchers say more research is necessary to understand discordance between child and parent reports of symptoms and its relationship to asthma morbidity experienced by the child.

Lara M, Duan N, Sherbourne C, et al.: Differences between child and parent reports of symptoms among Latino children with asthma. *Pediatrics* 1998; 102:68-111. For reprints, contact Marielena Lara, M.D., RAND Health, 1700 Main Street, Box 2138, Santa Monica, CA 90401-2138.

Brain abnormalities in childhood schizophrenia

Researchers from the National Institute of Mental Health obtained anatomic brain resonance images for 16 children and adolescents who had onset of schizophrenia by the age of 12. They then compared them to 24 age- and sex-matched healthy control subjects. Participants were scanned on initial admission and two years later using the same equipment and measurement methods.

Childhood schizophrenics showed a significantly greater increase in ventricular volume than control subjects did. There was a significant decrease in the midsagittal thalamic area among schizophrenics, which was unchanged during the second scan for control patients. Those brain changes in schizophrenics were correlated with the Premorbid Assessment Scale and the Brief Psychiatric Rating Scale at follow up.

"More consistent progressive ventricular enlargement was seen during adolescence or this childhood-onset sample than has been reported for adult-onset populations," the researchers conclude. "The brain imaging results support other clinical data showing both early and late deviations in brain development for at least this rare subgroup of treatment-refractory, very-early-onset schizophrenic patients."

Rapoport JL, Giedd J, Kumra S, et al.: Childhood-onset schizophrenia: progressive ventricular change during adolescence. *Archives of General Psychiatry* 1998; 54:897-903. For reprints, contact Judith L. Rapoport, M.D., Child Psychiatry Branch, National Institute of Mental Health, Building 10, Room 6N240, 10 Center Drive, MSC 1600, Bethesda, MD 20892-1600.

Sertraline found safe, effective for childhood OCD

Sertraline appears to be a safe and effective short-term treatment for children and adolescents with obsessive-compulsive disorder, according to a recent study.

Researchers conducted a randomized, double-blind, placebo-controlled trial of 187 patients ages six to 17 to assess the safety and efficacy of the selective serotonin re-

Recommended Reading

MANAGING ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN: A GUIDE FOR PRACTITIONERS — *Samuel Goldstein, Michael Goldstein. New York: John Wiley. 876 pages, $75.00 (hardcover), 1998. (800) 225-5945.*

TELLING SECRETS: AN ARTIST'S JOURNEY THROUGH CHILDHOOD TRAUMA — *Jane Orleman. Washington, D.C.: Child Welfare League of America (CWLA). 115 pages, $18.95, 1998. (800) 407-6273.*

What to do when your child is a bully

Parents most often discover their child has been bullying when the school principal calls with a complaint. Perhaps she tells you your child and his friend have been taunting and scaring a younger girl. Probably all you knew up to this point was that your child had a circle of friends. You may have had doubts about some of these friends, but nothing serious enough for you to act on.

Common patterns of bullying

A bully is cruel to a specific child over a long period of time. Bullying groups usually have a leader, who is physically stronger than most others his age. There are usually one or two followers who don't lead attacks on others but enjoy watching them or help come up with new ideas. If the child being bullied is disliked by classmates, more children may join in the bullying group.

Your child's bullying is not a reflection on you, but an indication that: (1) Your child has nothing more rewarding to do with his time; (2) He has fallen in with the wrong circle of friends.

Solving the problem: How to stop bullying

Step 1: Do not support bullying.

Nothing justifies bullying, even if the victim is disliked by most others. Give your child the clear message that what he did was wrong.

Step 2: Give your child six simple rules to prevent bullying.

Remove that portion of your child's life that was devoted to bullying. If the school principal has complained to you about bullying, reassure her that you are taking action. Make sure that the school also will supervise your child. You should tell your child:

- Stay away from the child you picked on.
- You are not allowed to hang out with the children who were bullying with you.
- Go directly to school and come directly home from school. (These are prime times for bullying.)
- When you invite children over, play only on our property so that I know where you are at all times.
- You are not allowed to visit someone else's house before I meet him and his parents.
- When you go to someone else's house, you need to stay where it is possible for his parent to see you at all times.

Step 3. Check on your child's activities outside your home.

Before accepting an invitation for a play date, always tell the host's parent that one of your rules is that your child be supervised at all times (you don't have to say why). After the play date, always ask the host's parent about the activity of the play date.

Step 4. Provide an immediate, brief penalty after one of the rules is broken.

Remember these guidelines:

- *Don't use any kind of physical response as a penalty.* Remember, you want to teach that physical intimidation is never acceptable.
- *Don't restrict other aspects of your child's*

Continued, over ...

life. You want him to acquire more productive interests. Never take away a play date with another child who doesn't bully.

- *Select a penalty you can enforce.* If your child has damaged another child's belongings, take away two or three weeks of his allowance to pay for part of it. It is not necessary for your child to totally repay the damage (although you need to offer to totally compensate the family of the injured child). Other appropriate penalties are restriction in TV time for the evening or missing a movie your child was planning to see.
- *Give the penalty immediately after you find out a rule has been broken.*
- *State the exact penalty before beginning it.* Examples:

  Mom: Since you destroyed that child's backpack, I'll pay your allowance for the next two weeks to him.

  or

  Mom: Since I saw you standing next to Alan and you weren't supposed to go near him, there will be no TV tonight.

  or

  Mom: You left the backyard when you were not supposed to. There will be no TV tonight.
- *After the penalty is over, do not discuss it further, and wipe the slate clean.*

Step 5: Keep track of rule violations.

If your child frequently breaks the rules you have set up, continue to impose penalties, but consider seeking professional help.

Adapted with permission from *Good Friends Are Hard To Find* by Fred Frankel, Ph.D., a psychologist and leading expert on children's social skills and director of the UCLA Parent Training and Children's Social Skills Programs. To order this book, contact Linda Goodman Pillsbury at Perspective Publishing (818) 502-1270.

The Brown University **Child and Adolescent Behavior Letter**

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uptake inhibitor antidepressant sertraline (Zoloft) for treating obsessive-compulsive disorder (OCD).

Treated children received a maximum of 200 mg daily during the first four weeks of therapy, then they received the medication for eight more weeks. Using measures such as the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) and the Clinical Global Impressions of Severity of Improvement (CGI-I) rating scale, investigators found that children treated with sertraline showed significantly greater improvement than placebo-treated patients. The differences in efficacy emerged after three weeks and persisted for the duration of the study. Based on CGI-I ratings at the end of the study, 42 percent of patients receiving sertraline vs. 26 percent of patients on placebo were very much or much improved.

Side effects such as insomnia, nausea and agitation were higher in patients receiving sertraline (13 percent) vs. patients on placebo (3.2 percent), but those symptoms tended to decline over time. There were no abnormalities in the children's vital signs, laboratory findings or electrocardiographic measurements.

March JS, Biederman J, Wolkow R, et al.: Sertraline in children and adolescents with obsessive-compulsive disorder. *Journal of the American Medical Association* 1998; 280:1752-1758. For reprints, contact John S. March, M.D., M.P.H., Pediatric Psychiatry, Duke University Medical Center, Box 3527, Durham, NC 27710.

Sex crimes

from page 1

too terrible crime. His actions will leave young women, and their families, damaged and traumatized long after this man has returned to the society too stupid and too naive to see the symptoms, heed the signs, hear the cries for help. He was a "family man," innocent until, eventually, proven guilty.

Now another school principal, also a "family man," stands accused of similar sexual assault charges: 48 of them.

This man is a native of a small village in Rhode Island, a former mill town, where folks know and protect their own. The wagons have already begun to circle around him, protecting him against the charges being brought against him by two young men, one of whom claims sexual abuse by the principal since the boy was 12 years old.

Good family men

The principal is apparently not gay. He is, instead, a red-blooded American guy. He grew up in the town where he is principal, married a local woman, and eventually settled in a nearby, more affluent city. When he became principal of his elementary school alma mater, the citizens cheered the return of a native son, and breathed a proud sigh of relief. Their children would be safe.

He was one of them, son of a local firefighter, Sunday school teacher, Little League coach, a good "family man" — innocent until proven guilty, they say.

When the first allegations were levied against the principal, school officials and others held the little secret close to their chests. He was suspended from his job with pay. His allies probably slapped him on the back, assuring him there was some "mistake." They knew him better than that, they thought. This was no pervert, no "faggot" they needed to protect their children from, no "sissy" they needed to fear.

He was like them, a "family man," innocent until proven guilty. And maybe he *is* innocent, but the reaction to his arraignment raises real questions about double standards.

The coach was considered innocent, and so was a married former priest who, having left his vocation to marry and have children, continued to sexually abuse young men and women across Massachusetts until scores of victims turned him in several years ago. So aren't they all, "good family men"?

Heterosexuals are not screened

Pedophiles seek gratification through the subjection of youngsters to their sexual will. Like adult rape, these are not crimes of passion or sex as much as crimes of power and control. Studies have consistently shown that pedophiles are not gay men and lesbian women most of the time, but heterosexual, usually impotent, generally married adults, often with children of their own.

There is no movement in America to screen the "family men and women" overseeing our kids. Instead, angry energy continues to be focused on the gay community, "guilty until proven innocent," which less often harms our children.

The witch hunters have been hunting the wrong witches. ■

Mary Ann Sorrentino, B.A., is a nationally syndicated columnist, based in Providence, RI. She has long been an advocate for gay rights. Adapted with permission from *The Providence Journal.*

S.T.A.R.
from page 1

the weekly lesson plan. Each class spends at least 20 minutes a week working on the monthly theme, such as Be friendly or Be polite. She says the language of the S.T.A.R. program has become a part of the children's daily conversations.

"One of the reasons [the S.T.A.R. program] works is because it doesn't take a huge effort to implement. There are a lot of English-language learners here and they might not know the words but they know the actions," says Rainville.

Use of rewards is an important factor in the program's effectiveness. Every month, two students in each class are identified as best representing that month's theme. The requirements are simple and easily achievable by any student. "Even if you don't have the best [school] work ... you may be a good listener or a good friend and for that you'll be rewarded," she says.

A systematic approach

Martial arts instructor Mike Rozumek took the material from the S.T.A.R. program and reworked it for the martial arts industry. Because the martial arts are steeped in the same ideals addressed in the S.T.A.R. program, he says a karate class is already aimed at teaching character education. The ideals of respect, discipline and responsibility are inherent in earning a black belt, and the S.T.A.R. program is a systematic way of instilling these values, with a manual and a set curriculum that fit in with karate's belt system, which is based on a series of short- and long-term goals.

Rozumek says his martial arts school's natural focus on self-discipline and good character traits offered a natural setting for the S.T.A.R. program's goals. The advantage for him was that the S.T.A.R. program offered a systematic approach that ensure the program's teachings would extend beyond the karate classes. He now acts as an adviser to others who wish to implement the S.T.A.R. program in their institutions.

Values homework

Chick Gavitt implemented the program at his Ichiban Karate Studio in Wakefield, R.I., in May and says it already has produced noticeable results in his students' attitudes and behavior. The younger students, ages 7 to 11, must perform monthly tasks based on themes that emphasize responsibility and values, such as "How can I show thanks?" and "How can I be a good friend?" This age group follows the Stop, Think, Act and Review method. After completing their assignments, the students complete a form listing ways in which they can and have shown gratitude or friendship. All forms are due at a specified time and must be signed by a parent.

If a student does not have the form ready to be handed in, he or she is not rewarded with a pin for his or her uniform. The instructors

Character education in progress

At age three, Joe Lole was diagnosed with "borderline attention deficit disorder," says his mother, Gretchen. It was suggested that he take Ritalin to control his behavior but she resisted. Four years ago, Joe's father died, and his behavioral problems increased. Now, at age 12, Joe has been taking karate classes at Ichiban Karate Studio for more than a year, and the adults in his life see a marked difference in his behavior.

With the tenets of the S.T.A.R. program and karate's tradition of discipline and respect influencing him on a daily basis, Joe's behavior improved without the use of medication, says his Mom. "This is the treatment we more or less chose. I'm not saying he's perfect, but sometimes he'll be in the middle of doing something he knows is wrong and he'll focus and realize this is not what he should do."

In Ichiban's karate program, in order for the grade-school students to earn another belt level, they must have their teacher sign a form attesting to their good work and respectful behavior in school. Parents also must sign the form attesting to their child's good behavior at home. "You have to do good in school to get a new belt," says Joe.

"He's more well-behaved. He has more respect and self-esteem. He has more self control. His grades have improved. It's improved the way he treats others," says Gretchen.

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Department of Education seeks to fund character education pilot projects

The Department of Education has announced the availability of funds to support pilot projects that design and implement character education. Under the Fund for the Improvement of Education, this grant will aid national programs to improve the quality of education, assist all students in meeting content standards and contribute to the National Education Goals, according to the December 14 Federal Register.

Under the character education program, state educational agencies will provide assistance to local educational agencies in developing and implementing character education curriculum. Applicants must propose character education projects that will incorporate the following: caring, civic virtue and citizenship, justice and fairness, respect, responsibility, trustworthiness and any other qualities appropriate to the program. Applications must also include a timeline and a narrative that explains the costs requested for each budget period.

Eligible applicants are state educational agencies, in partnership with one or more local educational agencies. Four million dollars are available to fund the program, with award amounts ranging from $100,000 to $1,000,000; up to 10 awards are available.

To request an application, call (202) 219-2053; voice mail (202) 219-2116; e-mail Judy_Collins@ed.gov; or write OERI/FIE Application, 555 New Jersey Avenue, NW, Washington, DC 20208-5645.

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review the completed forms and provide only positive feedback. Once the student completes a 12-month S.T.A.R. program, he or she will receive an achievement badge. There is no grace period for late forms and no replacing lost forms.

For the older students, ages 12 to 15, S.T.A.R. means Success Through Accepting Responsibility. Rather than monthly activities, these students are expected to perform community services each quarter. These activities may include a paper goods drive, visiting a senior center or working in a soup kitchen. For all students, good performance in school and good behavior at home is integral to success in the S.T.A.R. program. Teachers also must sign a child's form to verify good performance in school.

What motivates the students to participate? At first, the overall response from the students was not overwhelming, says Gavitt. The way the program was presented initially had a lot to do with that, so the instructors had to find a way to make it important to them. The pin worn on their uniform has come to be the tangible reward that inspires student participation, but all students in the program are left with a feeling of accomplishment, he says.

As to whether the program make good kids or whether good kids are more motivated to work the program, instructor Ken Berdeen, who works closely with students of all ages, says, "It's a little of both. Each child is different and will respond to the program in a different way."

Rozumek agrees, "Some need it [the character education] and some just need it reinforced."

The response from parents is generally positive and encouraging. The few parents who have reacted negatively to the program often feel that it's too much extra work.

Jamieson adds that some parents who feel strongly about teaching values at home may not want someone else introducing another values system to their children. "They think [the program's values] may not agree with theirs, [but] they change their minds after reading the manual."

Many parents enroll their children in martial arts classes hoping to provide them with structure and self-esteem. Schools offering the S.T.AR. program make this a priority. According to Gavitt, children with behavioral and psychological problems can benefit. "It allows kids with attention deficit disorder to focus." Good kids can excel and "kids with issues can become superstars," he added. "It's something that can make them better than what they are." ■

For more information on the S.T.A.R. program, contact The Jefferson Center for Character Education at 112 E. Lemon Avenue, Monrovia, CA 91016; or by phone at (626) 301-0403.

S.T.A.R. is designed to teach students to:

- Accept the consequences of their actions.
- Use the Stop Think Act and Review decision-making model to solve problems and resolve conflicts.
- Develop and improve self-confidence, self-esteem and positive attitudes.
- Set and achieve realistic goals.
- Accept that attendance, punctuality and reliability are part of being personally responsible.

Commentary

Defining moments are important influences on developmental destinies

Most people subscribe to a view of human development that makes two assumptions: (1) experience is cumulative, and (2) what happens early in life affects us later. These "uses of past experience" can facilitate or improve our lives or, alternatively, can have a deleterious effect upon our subsequent performances.

These suppositions hold that if we begin learning to read and do math when we are young, both should be easier when we're older. But if we grow up in a home of persistent verbal or physical abuse, such experiences often stifle learning and produce angry, hostile behavior later.

Along with this typically Western set of presumptions, we tend to believe, with good scientific authority, that heredity also counts. Our genes determine how we look, affect our mood swings and our pace in physical activity — even our ability to attend to the words of others. Of course, we may not know what our genetic limits or permissions are until we give them a try. There have to be opportunities that will facilitate the "expression of the genes." We can't know how high a dog can jump until we give the animal our best shot with optimal training procedures and learning opportunities. Knowing the species or breed provides an impression of what the limits might be, but records are broken all the time.

Many kids with awful histories have been turned around by the profound influence of a single person, a mentor.

Regardless of whether we believe *heredity* or the *environment* are more important — which is probably unanswerable without specifying the context, itself giving the edge to experience — we act as if the childhood environment is powerful. Isn't this why mommies and daddies are often so watchful of the experiences their kids have?

Recent authors have suggested that childhood experience is of minimal importance relative to the child's genes, and that parents' effects on their kids pale in comparison with the influence adolescents' friends have on them. This is tantamount to a denial of the cumulative effects of experience and even belittles parents' influence on children's peer choices!

Research into the life histories of young people, and clinical reports of people's descriptions of important influences on their developmental destinies suggest that an often overlooked source of our behavior is in what may be called *defining moments*.

Most adults, reflecting on their past, mention critical incidents or decisive conditions that occurred earlier in their lives. The high degree of "loyalty" that people have to these reported incidents or relationships suggest they are very important. These epiphanies warrant closer study.

Children reared under adverse conditions are more likely to have "bad life outcomes." However, many kids with awful histories have been turned around by the profound influence of a single person, a mentor. Vulnerable individuals often point to a "defining moment" when their risky patterns of behavior were reversed. Most recovering alcoholics, for example, point to a particular event causing extreme change in their behavior. They often cite the date and time, exactly, of their "conversion" — to no drinking or a major reduction. They refer in effect to a defining moment.

Many youths who have scrapes with the law point to the word of a judge or lawyer, the intervention of a scoutmaster or minister, or the sudden realization that someone else has been badly affected, causing them to "stop that behavior" and follow a different life routine.

I am asking friends and readers to give me examples of the magical efficacy of their own "defining moments." If you've had such an experience, may I hear of it? It could be a moment of pride, a moment of shame, any kind of incident of momentous import for your life, your perceptions of other people, or your understanding of yourself — sort of a "kick in the pants" or a "heads up!" Identify yourself or not, as you wish. The incident will not be used in any identifying way unless you give permission. Please send it to: Prof. Lewis P. Lipsitt, Department of Psychology, Brown University, Providence, RI 02912-9076; or by e-mail to llipsitt@brownvm.brown.edu. ■

Lewis P. Lipsitt

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

ADHD

Stimulants appear safe, effective, but questions remain

By Theresa Waldron

While a new consensus statement on the treatment of attention deficit hyperactivity disorder (ADHD) recently released by the National Institutes of Health (NIH) in Bethesda, Md., confirms that stimulant medications appear to be safe and effective, many questions remain unanswered. How long can the drugs safely be taken? Are they effective in the inattentive type of ADHD? (*For more on the ADHD Consensus Conference, see the Guest Commentary on page eight.*)

> ***'Taking medicine isn't going to teach them skills that they don't have ... That's where the combination of medication and (psychosocial) intervention may be useful.'***
>
> ***— Howard Abikoff, Ph.D.***

To date, only short-term studies — usually up to three months — have been conducted on stimulants such as methylphenidate (Ritalin) or pemoline (Cylert), says Howard Abikoff, Ph.D., professor of clinical psychiatry and director of research at the New York University Child Study Center in New York City. Abikoff spoke at a recent NIH-sponsored conference on ADHD where the consensus statement was developed. Although those studies have found that stimulants are effective against the symptoms of ADHD and associated aggressiveness, children with the disorder still have more behavioral problems than other children and may have difficulty with academic achievement or social skills.

(turn to 5)

Vol. 15, No. 2 February 1999

Inside This Issue

Tourette's associated with comorbid conditions. *See page 3*

Most children with head trauma observed for symptoms at home. *See page 4*

Guest Commentary: The ADHD Consensus Conference: End of the epidemic. *See page 8*

This month's client handout:
Understanding and managing children's anger

Public Policy

A "Help for Working Parents" program can reduce child poverty

By Barbara R. Bergmann, Ph.D.

The projected movement of millions of mothers into welfare jobs has concentrated attention on the fact that the wages most of them will earn will be low, and that many lack the ability to finance health insurance and decent child care, unless they get public help in paying for such services.

Judged by both rhetoric and appropriations, there is far less hostility to spending public money to buy services for the children of job-holding mothers than there is to sending cash payments to at-home mothers. Moreover, there appears to be some recognition, particularly among Republican governors, that welfare reform will be more likely to succeed if working parents are helped to obtain these services for their children.

This willingness to have government provide or finance services for working parents, and to help them by buying them big-ticket items like child care and health insurance, creates the possibility of an effective attack on the problem of child poverty. A close look at what families with children realistically need for decency shows that a single mother

(turn to 7)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

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Keep Your Eye On

... infant development.

Infant staring and squirming may seem inconsequential, but they may be important stages of development, when babies learn to "visually forage" their environment, say Cornell University researchers. Steven Robertson, Ph.D., professor of human development at Cornell in Ithaca, N.Y., explains that fetuses and newborns appear to engage in recurring cycles of motor activity. For example, infants stare at objects, then their motor activity escalates about one second before they look away. When their motor activity peaks, the infants' visual attention disengages, and motor activity immediately begins to subside. "Our studies suggest that these cycles may be an inherent characteristic of babies' nervous system development which allows them to process more information from the environment," Robertson notes.

For more information, contact Robertson at Cornell University, Surge 3, Judd Falls Road, Ithaca, NY 14853.

... school 'isolation room.'

A principal in Epping, N.H., has come under fire for using a padded "time-out" room for unruly elementary school children, creating debate among state educators about the use of isolation as discipline. The principal, Constance Carmody, says the room is used only for some children and not for punishment. "Students are never left alone, and the only purpose is to allow them time to calm down, to compose themselves, away from whatever situation caused the flare-up."

Nevertheless, superintendent Robert Bell says he doesn't believe in isolation rooms as a way to discipline children, and he ordered the room closed at Epping Elementary School. Carmody also was demoted as a result of the incident. (*Associated Press*)

... infant cocaine exposure.

More than one-third of the sickest infants seen at Yale-New Haven Hospital's emergency department recently tested positive for cocaine exposure, indicating that passive exposure to crack cocaine smoke may pose a health risk to young children. In the study, 36.3 percent of 122 infants, whose urine was examined because they were acutely ill, tested positive for cocaine. An additional 18.5 percent of infants showed possible traces of cocaine, boosting the total suspected cocaine exposures to 54.8 percent.

"We decided to check for cocaine after two children who had died of sudden infant death syndrome were found to have low levels of cocaine at autopsy," says Andrew S. Lustbader, M.D., a child psychiatrist and member of the research team. "Not only did we find a surprisingly high incidence of cocaine exposure in our sample of sick infants, we also found a high incidence of upper and lower respiratory symptoms such as runny nose, sore throat and asthma among those with measurable cocaine levels. Those infants also were brought in for medical care more frequently during the first year of life."

Lustbader suggests that future research should focus on the long-term effects of second-hand cocaine exposure and the link between cocaine and respiratory problems in the very young. There may be additional risks because many crack abusers also smoke cigarettes. It is possible that some of the infants in the study may have been exposed to cocaine through breastfeeding or ingestion, he adds. (*Yale News*, July 9, 1998. For more information, contact Cynthia L. Atwood, Yale University, P.O. Box 20879, New Haven, CT 06520-8279; phone (203) 432-1345.)

... fatal child abuse.

The presence of a biologically unrelated adult or non-parent in the home significantly increases the risk of fatal child maltreatment, according to researchers from Healthpartners in St. Paul, Minn., and the University of Missouri in Columbia. In a case study comparing children who died from maltreatment to children who died from natural causes or sudden infant death syndrome, the researchers found that injury death due to maltreatment among children under age five was six times greater when there was a biologically unrelated adult or adult not in the social role of parent in the home. There was no increased risk of injury death associated with the presence of related adults in the household. (*American Academy of Pediatrics Annual Meeting*, October 16-21. For more information, contact Gina Steiner, American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098; phone (847) 981-7872.

... low self-esteem.

New research suggests that low self-esteem in adolescents does not lead to later delinquent behavior. "It's been accepted in American society that low self-esteem is at least partially to blame for juvenile delinquency, but we don't find support for that theory," says Sung Joon Jang, Ph.D., co-author of the study and assistant professor of sociology at Ohio State University in Columbus.

A total of 830 high-risk, urban Rochester, N.Y., public school students were interviewed three times between their eighth- and tenth-grade years of school. They were asked questions that measure self-esteem and they were asked about the number of their friends who were involved in property crimes, violent crimes or status offenses such as truancy. The participants also were asked how often they participated in those crimes.

The study found that teens with low self-esteem weren't more likely to engage in delinquency later, but that associating with delinquent friends did enhance their self-esteem later.

"Teens who feel rejected by conventional groups like their family may find some level of acceptance from delinquent peers," says Jang. "The key is that it was the delinquent friends — not the delinquent acts — that [were] responsible for boosting self-esteem."

The results were generally true for both boys and girls and for African-Americans, whites and Hispanics.

"Self-esteem is an important concept for understanding human behavior, but it doesn't provide answers to all the problems teenagers face," Jang concludes.

For more information, contact Sung Joon Jang, Ph.D., at Ohio State University, 1125 Kinear Road, Columbus, OH 43212-1153; phone (614) 292-6686; e-mail: Jang.11@osu.edu.

What's New in Research

Tourette's associated with comorbid conditions

Many children with Tourette's disorder experience sudden, explosive episodes of rage. This clinical phenomenon resembles intermittent explosive disorder and may reflect specific underlying neurologic disturbances, according to recent research.

Through a pilot study of 12 children with Tourette's disorder and rage attacks, investigators sought to determine if the children also had comorbid conditions such as obsessive-compulsive disorder (OCD).

The two girls and 10 boys, ages 10 to 17, were evaluated for diagnosis, presence of comorbid disorders, and tic severity using DSM-IV diagnostic criteria and standardized rating scales.

All participants met the diagnostic criteria for Tourette's disorder, and were diagnosed with mild tic severity. All met criteria for OCD and attention-deficit/hyperactivity disorder (ADHD). Two children were diagnosed with oppositional defiant disorder and four were diagnosed with conduct disorder. None of the children was diagnosed with a mood disorder.

This study suggests that rage attacks in Tourette's disorder may be related to the presence of comorbid disorders, the authors conclude.

Budman CL, Bruun RD, Park KS, et al.: Rage attacks in children and adolescents with Tourette's disorder: A pilot study. *Journal of Clinical Psychiatry* 1998; 59:576-580. For reprints, contact Cathy L. Budman, M.D., Departments of Neurology and Psychiatry, North Shore University Hospital, New York University School of Medicine, 400 Community Drive, Manhasset, NY 11030.

First trimester growth associated with LBW

A recent study sought to determine if low birth weight (LBW) risk and birth weight are related to embryo or fetus size during the first trimester of pregnancy.

Researchers identified women with no medical problems, a normal menstrual history, and a first-trimester ultrasound scan from a database of ultrasound records of 30,000 pregnancies. They determined crown-rump length of the embryo or fetus, then examined the relationship between the outcome of 4,229 pregnancies. They also determined the expected crown-rump length in the first trimester by equivalent days of growth.

A first-trimester crown-rump length that was smaller than expected (by two to six days) was linked to a higher risk of LBW (below 2,500 grams), LBW at term, a birth weight below the fifth percentile for gestational age, and delivery between 24 and 32 weeks' gestation.

"Suboptimal first-trimester growth may be associated with low birth weight, low birth-weight percentile, and premature delivery," the researchers conclude.

Smith GCS, Smith MFS, McNay MB, et al.: First-trimester growth and the risk of low birth weight. *New England Journal of Medicine* 1998; 339:1817-1822. For reprints, contact Gordon C.S. Smith, M.D., Laboratory for Pregnancy and Newborn Research, Department of Physiology, College of Veterinary Medicine, Cornell University, Ithaca, NY 14853.

Recommended Reading

Children of Trauma: Stressful Life Events and Their Effects on Children and Adolescents — *T.W. Miller (Ed.). Madison, CT: International Universities Press. 267 pages, $42.50, 1998. (800) 835-3487.*

Families, Risk and Competence — *M. Lewis, C. Feiring (Eds.). Mahway, NJ: Lawrence Erlbaum Associates. 350 pages, $79.95 (hardcover), $39.95 (paper), 1998. (800) 926-6579.*

Growing Up in a Lesbian Family: Effects on Child Development — *F.L. Tasker and S. Golombok. New York: Guilford Press. 187 pages, $35 (hardcover), $17.95 (paper), 1997. (800) 365-7006.*

Prior misdemeanors linked to firearm activity

Recent research indicates that handgun purchasers with prior misdemeanor convictions are at increased risk for future criminal activity, including violent and firearm-related crimes.

Because many people with prior convictions for misdemeanor offenses are able to pass criminal record checks and legally purchase handguns, researchers sought to determine whether those people are more likely than people without prior criminal history to be charged with new crimes involving firearms and violence.

They conducted a retrospective, 15-year cohort study of 5,923 authorized purchasers of handguns in California in 1977. The purchasers were younger than age 50, and 3,128 had at least one conviction for a misdemeanor offense prior to handgun purchase.

The researchers found that handgun purchasers with at least one prior misdemeanor conviction were more than seven times as likely as those with no prior criminal history to be charged with a new offense after handgun purchase. In addition, among males, those with two or more prior convictions for misdemeanor violence were at greatest risk for nonviolent firearm-related offenses such as weapon carrying, violent offenses generally and violent crime index offenses such as murder or forcible rape.

Handgun purchasers with only one prior misdemeanor conviction and no convictions for offenses involving firearms or violence were almost five times as likely as those with no prior criminal history to be charged with new offenses involving firearms or violence.

Wintermute GJ, Drake CM, Beaumont JJ, et al.: Prior misdemeanor convictions as a risk factor for later violent and firearm-related criminal activity among authorized purchasers of handguns. *Journal of the American Medical Association* 1998; 280:2083-2087. For reprints contact Garen J. Wintermute, M.D., M.P.H., Violence Prevention Research Program, University of California-Davis Medical Center, 2318 Stockton Blvd., Sacramento, CA 95817. e-mail: gjwintermute@ucdavis.edu.

Most children with head trauma observed at home

A recent survey suggests that most physicians choose clinic or home observation for initial management of minor pediatric head trauma.

UNDERSTANDING AND MANAGING CHILDREN'S ANGER

For young children, anger has three components. The emotional state, the expression of the anger and the understanding of the emotion. The emotional state is experienced when goals are blocked or needs are frustrated. For example, if the child's goal is to play with a new toy, and he is then asked to give it away (which is what sharing means to young children), the child becomes frustrated because this goal — to use the toy — is blocked. This causes stress for the child.

There are several types of stress producing anger provocations that young children face in daily interactions. Some of these include:

- Conflict over possessions — This is the most common and involves someone taking or destroying property or invading the child's space.
- Physical assault — A child is pushed, shoved or hit.
- Verbal causes — Someone teases or taunts the child.
- Rejection - A child is ignored or not allowed to play.
- Issues of compliance — A child is asked to do something he or she does not want to do and feels his independence is blocked by the adult's request for compliance.

The second component of anger of expression. This unpleasant emotion is the first experienced in infancy. Children who have their goals blocked attempt to cope by expressing anger. This is done through facial expressions, crying, sulking or talking. They do little to solve the problem. Others use active resistance by physically or verbally defending their position, self-esteem or possessions in a non-aggressive manner. Children that resort to name calling or physically retaliating by hitting use aggressive revenge. The last two methods used are avoidance and adult seeking. Avoidance is making an attempt to escape the situation, and adult seeking serves to get attention and comfort from care providers.

The third component of anger is understanding and evaluating the emotion. Children need guidance from adults to understand and manage their emotions. While adults can't change the situations children get into that produce anger, there are ways to help.

- Create a safe, emotional environment
- Model responsible anger management
- Help children develop self-regulatory skills
- Encourage children to label feelings of anger.
- Encourage children to talk about anger-

Continued, over ...

arousing interactions.

- ✓ Use appropriate stories about anger to help children understand and manage.

Remember, children are not immune to the same social pressures that adults experience.

Amie Spencer is director of child development programs at Beech Acres, The General Protestant Orphan Home in Cincinnati, Ohio. Reprinted with permission from Beech Acres' *In Touch* newsletter.

The Brown University **Child and Adolescent Behavior Letter**

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Pediatricians, family physicians and emergency physicians from a random sample of the American Academy of Pediatrics and other organizations were given clinical vignettes describing children presenting with normal physical examination results after experiencing minor head trauma. Different clinical scenarios such as brief loss of consciousness or seizures also were included.

Of 765 surveys that were returned, for minor head trauma without complications, observation at home was chosen by 547 (72 percent) of physicians. Observation in office or hospital was chosen by 81 (11 percent) of physicians, and head computed tomographic (CT) scan was chosen by seven (1 percent) of physicians. Twenty-four (3 percent) chose skull x-ray.

Eighty percent of respondents noted they would obtain a CT scan if the patient showed clinical deterioration after going home. If the patient had lost consciousness during the injury, 383 (58 percent) said they would alter management with CT scan, x-ray, magnetic resonance imaging (MRI), inpatient observation, or a combination of CT scan and observation.

If the patient had a seizure following head trauma, 176 (27 percent) chose CT scan, five (1 percent) chose skull x-ray, and 60 (9 percent) chose inpatient observation. In addition, 299 (45 percent) chose a combination of radiological evaluation and observation if the patient had a seizure.

"Clinical management was more varied when patients had sustained either loss of consciousness or seizures," say the investigators. "Further study of the appropriate management of minor head trauma in children is needed to guide physicians in their care."

Aitken ME, Herrerias CT, Davis R, et al.: Minor head injury in children: current management practice of pediatricians, emergency physicians, and family physicians. *Archives of Pediatrics and Adolescent Medicine* 1998; 152:1176-1180. For reprints contact Mary E. Aitken, M.D., Department of Internal Medicine, Box 356522, University of Washington Medical Center, 1959 Northeast Pacific St., Seattle, WA 98195.

Resources

Videos focus on teaching social skills to youngsters

The Bureau for At-Risk Youth has developed five motivational videos under its "Kelly Bear" character education program for youngsters who are in pre-kindergarten through third grade. The videos feature a life-size green bear named Kelly, who serves as a teacher and hero to five children. Videos include additional youngsters who interact with the author in a classroom, playgroup and home setting. The videos focus on teaching vital social skills such as respect, friendship, anger management and refusal skills. For more information, write The Bureau for At-Risk Youth, P.O. Box 760, Plainview, NY 11803-0760; or call (800) 99-YOUTH.

Guide addresses OCD in children, adolescents

A patient guide from the University of Wisconsin-Madison Department of Psychiatry on obsessive-compulsive disorder (OCD) in children and adolescents is available. The guide contains chapters on commonly asked questions about OCD in children; children and adolescents with OCD at school; treatments for OCD; anti-OCD medications and their side effects; and OCD and the family. The cost of the 57-page booklet ranges from $4.50 per copy for one to nine copies to $2.50 per copy for more than 50 copies. For more information, write Dean Foundation, 2711 Allen Blvd., Middleton, WI 53562; or call (608) 827-2390.

ADHD

from page 1

"This is a really perplexing problem for those of us who work in this area," says Abikoff. "We know that when they take medication, the children's' performance academically improves. They do more work, and the work they've already mastered, they're able to do more accurately ... But what it doesn't do is make up for all the skills they have never mastered. They may still be behind and have concomitant learning problems and even learning disorders. The medication by itself isn't going to address that at all."

Social skills may still be lacking

Although stimulants help children with ADHD be less aggressive and intrusive with others, many of them still have to master positive social skills.

"Taking medicine isn't going to teach them skills that they don't have, and as a result, they are still, even with the medication, going to be deficient in those pro-social skills if they were problematic to begin with," Abikoff says. "That's where the combination of medication and [psychosocial] intervention may be useful."

Peter S. Jensen, M.D., associate director of child and adolescent research at the National Institute of Mental Health (NIMH) in Rockville, Md., says the consensus statement indicates that the stimulants are safe and effective for up to 14 months, although there are no long-term data on safety and efficacy after that time.

"We at NIMH believe [we] need to mount some systematic research program that will investigate the longer-term issues of safety," Jensen says. "I think efficacy is less pressing, because it's quite clear that short-term efficacy is there, and all evidence we have indicates that children who respond early on [to stimulants] are going to continue to respond at later ages."

What about individual differences in stimulant medications? The consensus statement makes the point that there are "few, if any, differences" among them except for differences in dosing.

"Adderall [amphetamine], for example, seems to have a longer half-life," Abikoff notes. "Because it's metabolized more slowly, it provides an opportunity perhaps for less frequent dosing during the day. That can make a difference for kids who may be opposed to taking something during the school day."

Desipramine used second-line

The tricyclic antidepressant desipramine (Norpramin), has been studied and found to produce some improvements over placebo in parent and teacher ratings of ADHD symptoms, according to the consensus statement. However, because of concern over possible cardiac side effects such as heart palpitations with the drug, it is considered second-line therapy, Abikoff adds.

"There are enough concerns that clinicians will usually not use it as a first course of action at all," he notes.

Jensen says a common problem with stimulants is that they are prescribed incorrectly. He says the most common prescribing error is underdosing.

"Children are probably not receiving a therapeutic dose that results in the best maximal improvement in home and school settings," he notes. "Frequently, a pediatrician will give 5 or 10 mg [of methylphenidate daily]. They also often won't give the third dose. The third dose — as we call the 'homework dose' — is often very important in terms of parents being able to see maximal benefit and children being able to maximize their school-based performance."

The third dose is typically given at about 4 p.m., Jensen adds. If children have difficulty with insomnia or other side effects with the third dose, it can be given in a dose that is half the amount of the morning and noon doses.

The consensus statement also addresses psychosocial treatments of ADHD. Interventions that appear to work best include clinical behavior therapy, parent training, and contingency management. However, behavioral treatments without medication do not appear to be effective in managing the symptoms of ADHD. It is not known whether behavioral treatments can improve functioning and thus allow clinicians to reduce the dose of stimulants. ■

Major conclusions of the ADHD consensus statement:

- There are many unknowns regarding ADHD drug therapy, including the best treatment for ADHD, inattentive type, which is common in girls. There also are no conclusive data on treating adolescents and adults with ADHD. In addition, there is little information about the effect of medications on cognitive problems associated with ADHD, such as memory processing deficits.
- There often is poor communication between parents, pediatricians, teachers, school psychologists, and others who are involved in diagnosing and treating ADHD. There should be "school teams" of practitioners involved in the care of children with ADHD that meet regularly to assess progress of medication and other interventions.
- More research is needed, especially in these areas: the coexisting conditions that often occur with ADHD, the inattentive type of ADHD, the safety of long-term drug treatment, the effects of stimulants on school performance and cognitive function, the effects of psychosocial treatments, and the treatment of children younger than age five.

The consensus statement is available on the World Wide Web at http://odp.od.nih.gov/consensus/.

Child poverty

from page 1

with two pre-school children working full-time in even the lowest wage job can achieve a decent level, provided she has government help in paying for child care and health care, and gets some help on housing costs in high-rent areas. Indeed, a "Help for Working Parents" (HWP) program that would give all lower-wage parents, not just those coming off welfare, assistance with their child care and health care needs would have the potential to reduce child poverty in the United States to a significant degree. Programs of this type help keep child poverty low in other advanced countries. In France, for example, the child poverty rate is 6 percent, as contrasted with the American child poverty rate of 22 percent.

The HWP program would deliver major resources to the millions of families with children who despite significant work effort cannot support their children in decency. It would do so in a way that would not discourage working or marriage, as AFDC did, and in a form that would directly benefit children. The accusation that people are having children just to get benefits could not be applied to the HWP.

The cost of providing a two-child single-parent family with child care and health insurance (assuming that the parent's job does not provide health insurance) would be $14,000. For this, the taxpayers would be buying the family access to health care, a movement of the children to high-quality care, and a rise in the family resources equal to the amount the family currently spends on child care and health care, including health insurance. The program would greatly facilitate job-holding on the part of the parents. The cost of instituting a HWP program would depend on the details, but a program on the order of $60 billion per year would be feasible.

Alternative approaches won't do the job

Tax breaks for families with children have been popular with both the right and left. The budget passed in 1997 granted a non-refundable tax credit of $500 per child. These tax breaks eat up large sums of budget money, but have far less effect in reducing deprivation among the children of low-wage parents than would the HWP program. The HWP concentrates help in two ways: on low-income parents with children under 12 years old. The recently passed tax credit will give these parents nothing; had the credit been refundable, they would have gotten only $1,000.

Another suggested approach to reducing child poverty has been labor market policies that would improve the employability and wages of young parents in the lower strata of the labor market — skills training programs, the creation of public sector jobs, raising the minimum wage, improving the coverage of the unemployment insurance system. These suggestions are constructive ones, but again are poorly targeted toward reducing child poverty. There is no possibility that such an approach would bring anything approaching the $14,000 of help to the worst-off working families, which the HWP program provides in a form that is tailor-made to meet the needs of children.

A serious attack on child poverty

A crucial roadblock in the way of a large-scale government program to reduce child poverty is the idea that the United States "can't afford" to spend more on social welfare programs, even those that would be of high value. A U.S. politician who says we "can't afford" to provide child care and health insurance for lower and middle income families cannot mean that it would be impossible or imprudent for us to do so. After all, such a program could be financed by a modest rearrangement of the budget, taking funds from programs of lower national priority.

The claim that we "can't afford" it allows the politician to avoid saying that we have better things to do with our resources than mobilizing them to improve child well-being in this country, (through higher taxes, or reducing other expenditures, or borrowing), and that these better things include the B-2 bomber, farm subsidies, or spending for still more luxuries by the upper income groups. That wouldn't sound good or responsible.

But a costly and activist program is really our only alternative if we are to make progress against child poverty. We do not have it in our power to create through a government policy or through moral suasion or through religious revival a country and a society where some help to low-earning parents and their children would be needed. A move back to the social customs of the 1920s is not available to us, but a $60 billion program that would drastically reduce child deprivation is available. ■

Barbara R. Bergmann is Professor Emerita of Economics at American University and University of Maryland. Her most recent books are *Saving Our Children from Poverty: What the United States Can Learn from France* (Russell Sage Foundation) and *In Defense of Affirmative Action* (Basic Books).

Guest Commentary

The ADHD Consensus Conference: End of the epidemic

By Fred A. Baughman, Jr., M.D.

Failing to ask whether or not ADHD is an actual disease, with a confirmatory, physical abnormality (the definition throughout medicine), the media remains a vector essential to the persistence and spread of the epidemic. Without an iota of proof or credible science, the National Institute of Mental Health (NIMH) has proclaimed the behaviors of ADHD a disease, and the children "brain-diseased" or "abnormal."

Children and Adults with Attention Deficit Disorders (CHADD), 35,000-strong, funded by Ciba-Geigy, manufacturer of Ritalin, has spread the neurobiological lie. The U.S. Department of Education, absolving itself of controlling the children and rendering them literate, coerces the labeling and drugging. The "epidemic" has zoomed from 150,000 in 1970 to five million in 1997. Ritalin production rose 700 percent.

As a neurologist making "disease" vs. "no disease" determinations daily, I have discovered and described real disease, but found no disease in children in ADHD — no abnormality. Nor does the scientific literature hold proof that ADHD is a disease — that the children are "diseased" or "abnormal."

Kety and Matthysse[1] conclude the "literature does not provide ... evidence... for ...biological differences that may characterize the brains of patients with mental disease." The Congressional Office of Technology Assessment[2] concludes: "Mental disorders are classified on the basis of symptoms because there are ... no biological markers or laboratory tests ..." (no way of confirming that any are actual disease). Ernst,[3] an ADHD researcher, laments: "The definition ... has changed over time ... making comparisons among studies difficult. ... Children ... diagnosed according to DSM-III-R ... may not meet DSM-III criteria."

What manner of disease is this? I have written regularly to ADHD authorities asking that they refer me to articles in the peer-reviewed, scientific literature that constitute proof that ADHD is a disease with a confirmatory, physical abnormality.

Leber[4] of the FDA responded "... no distinctive pathophysiology [abnormality] for the disorder has been delineated." Haislip[5] of the DEA wrote "We are ... unaware that ADHD has been validated." Castellanos[6] of the NIMH confessed: "... we have not yet met the burden of demonstrating the specific pathophysiology ... we are motivated by the belief that it will be possible in the near future to do so." Carey[7] of the University of Pennsylvania replied "There are no such articles. There are many articles raising doubts, but none that establish the proof you or I seek."

Addressing the subject "Is ADHD a valid disorder?" at the November 1998 NIH Consensus Conference on ADHD, Carey[8] concluded "... common assumptions about ADHD include that it is clearly distinguishable from normal behavior, constitutes a neurodevelopmental disability, is relatively uninfluenced by the environment. ... All of these assumptions ... must be challenged because of the weakness of empirical [research] support and the strength of contrary evidence. ... What is now most often described as ADHD in the United States appears to be a set of normal behavioral variations. ... This discrepancy leaves the validity of the construct [ADHD] in doubt..."

With no proof with which to counter Carey's assertions, the final statement of Consensus Conference on ADHD (11/18/98) read: "... we do not have an independent, valid test for ADHD, and there are no data to indicate that ADHD is due to a brain malfunction."

It is time for the media to pose the "Is it a disease or isn't it?" question, to demand a straight answer and to share it with the public.

Fred A. Baughman Jr., M.D., practices neurology and pediatric neurology in La Mesa, CA. He has authored more than 100 publications on a variety of neurological, pediatric, medical and educational topics.

References:

[1] Kety SS, Mattysse S: The New Harvard Guide to Psychiatry. Harvard University Press, 1988, p. 148.

[2] Congress Office of Technology Assessment. The Biology of Mental Disorders. U.S. Government Printing Office, 1992, p 13-14, 46-47.

[3] Ernst M. Neuroimaging in Attention-Deficit/Hyperactivity Disorder. In: Nadeau KG (ed.). A Comprehensive Guide to Attention Deficit Disorder in Adults. Brunner and Mazel, Inc. New York. 1995.

[4] Leber P: Division of Neuropharmacologic Drug Products, FDA, personal correspondence, December 24, 1994.

[5] Haislip GR, Office of Diversion Control, DEA, personal correspondence, October 25, 1995.

[6] Castellanos FX, NIMH, personal correspondence, May 13, 1998.

[7] Carey WB, Children's Hospital of Philadelphia, personal correspondence, August 5, 1998.

[8] Carey WB. NIH, Consensus Development Conference on ADHD, November 16-18, 1998.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Family life

Changes in American children's time, 1981-1997

By Sandra L. Hofferth, Ph.D.

Family life has changed significantly since 1980. In 1997 two-thirds of the mothers of preschool children were working, compared with 47 percent in 1980 and 12 percent in 1950. This is a remarkable number. The employment of mothers of young children has had a major effect on family life, just as the initial movement of men out of the home and into wage employment did at the beginning of the industrial revolution.

In recent research at the University of Michigan, we focused on changes in children's experience of family life over the 16-year plus period between 1981, when the first such study was conducted, and 1997. Both studies used the same time diary method. The two major findings of our research are that, first, children's free time has declined and second, that free time is increasingly structured. To find out how much free time children had in 1981 and 1997, I summed discretionary time, defined as time not spent in personal care, eating, sleeping and school, and divided by the 168 hours in each week. That amounted to 38 percent of a child's week (63 hours) in 1981 and 30 percent (51 hours) in 1997, a 16 percent decline in free time over the past 16 years.

Household conversations, that is, just sitting and conversing, declined by 100 percent ... from 1981 to 1997.

The major causes for this decline are the increased

(turn to 5)

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Inside This Issue

Keep Your Eye On:
Functional MRI looks promising for identifying children with ADHD. *See page 2*

Mild behavior, sensory problems in premature infants usually resolve. *See page 3*

What's New in Research:
STD rates among youth decline after intervention. *See page 3*

Commentary:
Prescriptive child rearing. *See page 8*

This month's client handout:
End the grocery store wars

Criminal Behaviors

Adolescent male sex offenders challenge therapists' skill

By Joyce F. Lakey, M.S., L.C.S.W.

Counseling adolescent male sex offenders draws on every skill a therapist can muster. These clients approach therapy with all the cunning and deceit their adult counterparts demonstrate. At first — with rare exception — they are recalcitrant participants because they are painfully aware that treatment implies change, and change is difficullt.

An adolescent sex offender may be defined as a youth, ranging from puberty to the age of legal majority, who commits any sexual interaction with a person of any age against the victim's will, without knowing consent, or in an aggressive, exploitative or threatening manner. Thus, a 14-year-old boy who forces himself on an elderly, intellectually handicapped neighbor for his own sexual pleasure shares the same legal category as a 16-year-old who manipulates a six-year-old brother or sister into consensual mutual fondling.

To understand how to direct the task of counseling and treatment, one must understand the character of the clients. Certain shared char-

(turn to 7)

The Brown University **Child and Adolescent Behavior Letter**

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

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Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

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Keep Your Eye On

... infant formula.

Feeding premature infants an enriched formula can improve their intelligence, say British researchers. In a 16-year study from Britain's Medical Research Council, physicians found that premature infants who had been fed an enriched formula had better scores on intelligence tests at ages 7.5 and eight years old than children of the same age who had been premature and hadn't been fed the enriched formula.

There were more than 400 babies in the study. Verbal intelligence quotient (IQ) scores below 85 were more common in children who had been fed standard formula, especially among boys.

"This study provides a clear illustration that early nutrition of premature babies can have profound lifetime effects on brain development, suggesting the idea that diet during critical periods in early life may be of great importance for our health and performance as adults," says Alan Lucas, M.D., a study researcher.

... brain scans for ADHD.

A brain scan referred to as a "functional MRI" (magnetic resonance imaging) may be able to identify children with attention-deficit/hyperactivity disorder (ADHD), say researchers at Stanford University in Palo Alto, Calif. Although the brain scan needs further testing — and costs more than a regular MRI, which has a price tag of $1,500 or more — the new technique "looks very promising," says John Gabrieli, a researcher at Stanford's Department of Psychology.

The brain scan would make the diagnosis of ADHD more specific, allowing for a more "valid and consistent diagnosis," adds Gabrieli.

In a Stanford study of 16 boys ages eight to 13, the brain scan was used while the boys played a simple mental game where letters of the alphabet were flashed individually on a screen. Ten of the boys had been diagnosed with ADHD; six did not have the disorder. The boys were instructed to push a button for every letter except the letter "X." Since poor concentration and impulse control are signs of ADHD, the patients with the disorder performed more poorly in that they were more likely to push a button for the letter "X" than the boys without ADHD.

The boys were then tested after being given methylphenidate (Ritalin), and the drug improved performance in both groups of boys. When the brain scans were compared on the drug, the boys with ADHD had more activity in the basal ganglia portions of their brains than before they took methylphenidate; boys without the disorder had less activity in the basal ganglia.

The test was found to give a "brain signature" to more accurately identify ADHD, says Gabrieli, but it is still preliminary and must be tested further in both boys and girls. (*The Associated Press*)

... behavior problems in preemies.

New research indicates that although premature babies tend to have mild behavior and sensory response problems, most eventually develop normal motor and mental function. Jane Case-Smith, associate professor of allied medicine at Ohio State University in Columbus, and colleagues looked for signs of difficult behavior and abnormal sensory responsiveness in 45 babies who were born more than a month early. The babies, who averaged 12.2 months of age at the time of the study, were born at an average of 29 weeks' gestation — or 11 weeks early. The infants had spent at least two weeks in a neonatal intensive care unit at Children's Hospital in Columbus before being discharged after birth.

Case-Smith used a questionnaire for primary caregivers regarding infant response to touch, movement, hearing, vision and temperament. She also used an infant development test to assess the babies' mental and motor skills. They compared the results to a group of 22 full-term babies.

The results indicate that preterm babies had slightly lower mental development scores than did full-term babies, but that mental scale scores were comparable between the two groups. The premature babies had a greater tendency to bite objects, to arch their backs when held, to touch others, and to spin and rock while sitting.

"Premature babies seem to make up for their lack of early sensory experience in other ways," Case-Smith explains. "Some of the behaviors often seen in preterm infants such as biting are appropriate sensory-seeking behaviors for this age group. These behaviors may be seen more frequently in preterm infants, but they don't suggest developmental problems."

She adds that there was no correlation between developmental scores and sensory problems, which suggests that they don't interfere with development.

"Parents need to understand that while there may be some behavioral differences, chances are their preterm baby will develop normal sensory responsiveness," Case-Smith explains.

For more information, contact Case-Smith at The Ohio State University, 1125 Kinnear Road, Columbus, OH 43212-1153; phone: (614) 292-0357; e-mail: Case-Smith.1@osu.edu.

... lower infant mortality.

The U.S. infant mortality rate was at an all-time low in 1997, at 7.1 deaths per 1,000 live births. That is the lowest rate on record and 3 percent lower than the rate for 1996. The lowest infant mortality rate occurred in Maine, with 4.4 deaths per 1,000 live births; the highest rate occurred in the District of Columbia, with 14.1 deaths per 1,000 live births.

In addition, a higher percentage of pregnant women sought prenatal care during their first trimester in 1997 (82.5 percent) compared to 1996 (81.9 percent). Hispanic mothers who received late or no prenatal care decreased from 6.7 percent to 6.2 percent from 1996 to 1997. There was no change in the rate for white or African-American mothers.

Low birth-weight rates were at the highest level reported since 1973, however, because of the increase in multiple births. There was a 5 percent increase in multiple births in 1996 compared to 1995. But the multiple birth rate (triplets and greater) climbed to 20 percent for 1996, the largest single year increase in at least 25 years. The rate of teenage pregnancies dropped for the sixth consecutive year in 1997 as well. (*American Academy of Pediatrics*.) For more information, contact Shari Schmidt, American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098; phone: (847) 981-7131.

What's New in Research

STD rates lower after intervention

Recently published research indicates that sexually transmitted disease (STD) risk assessment and education tools administered in a single office visit facilitated STD/HIV prevention education. However, the researchers say, "Any impact on sexual activity and condom use was short-lived."

Participants in the study were 12- to 15-year-olds at five managed care sites in Washington, D.C. The research was designed to determine if risky sexual behaviors could be prevented by risk assessment and education tools provided as part of office-based primary care services. The randomized intervention trial included three- and nine-month follow-ups of 215 youth by 19 pediatricians; 81 percent were minority youth. Ninety-two percent (197) of participants completed the study.

The intervention consisted of an audiotape on STD risk assessment and education about staying safe by using condoms or practicing abstinence. The main outcome measures of the study were adolescent-reported sexual intercourse and condom use.

More sexually active adolescents reported condom use in the intervention group at three months, and at nine months, there were more signs of STDs in the control group (7/103) than the intervention group (0/94). Further research is needed to develop brief, office-based sexual risk reduction for young adolescents.

Boekeloo BO, Schamus LA, Simmens SJ, et al.: A STD/HIV prevention trial among adolescents in managed care. *Pediatrics* 1999; 103:107-115. For reprints, contact Bradley O. Boekeloo, Ph.D., M.S., University of Maryland, Department of Health Education, College of Health and Human Performance, College Park, MD 20742.

Mood stabilizers effective in children with mania

In a recently published study, researchers systematically reviewed clinical records of pediatric patients who were consecutively referred for mania on a structured diagnostic interview. The reviewers assessed the course of manic-like symptoms and all medications prescribed at each follow-up visit.

They then used survival analysis to determine the effect of mood stabilizers and other medications on the course of the children's manic-like symptoms. The medications assessed in the study included lithium (Eskalith and others), valproic acid (Depakote and others), carbamazepine (Tegretol), antidepressants, antipsychotics, and stimulants.

Of the 59 patients who met criteria for mania, 44 (75 percent) showed evidence of manic-like symptoms during follow-up, and the occurrence of manic-like symptoms significantly predicted the subsequent prescription for mood stabilizers. The use of mood stabilizers also predicted decreases in manic symptoms. Improvement was slow, however, and associated with a substantial risk for relapse, the investigators report.

Mood stabilizers were frequently used in children with manic-like symptoms, and their use was associated with significant improvement of manic-like symptoms, whereas use of antidepressant, antipsychotic and stimulant medication was not, they conclude.

The researchers add that further research is needed to better define the role of individual mood stabilizers as single or combined treatments for juvenile mania.

Biederman J, Mick E, Bostic JQ, et al.: The naturalistic course of pharmacologic treatment of children with maniclike symptoms: a systematic chart review. *Journal of Clinical Psychiatry* 1998; 59:628-637. For reprints, contact Joseph Biederman, M.D., Pediatric Psychopharmacology Unit, ACC 725, 15 Parkman St., Boston, MA 02114.

Weapon carrying linked to abuse, other factors

Investigators examined the association between carrying a weapon at school and the age of onset of substance abuse, other indicators of violence, and other health risk behaviors among middle school students. They used data from a modified version of the Centers for Disease Control and Prevention Youth Risk Behavior Survey administered to 2,227 students attending 53 randomly selected middle schools in North Carolina.

Weapon carrying on school property during school hours was measured with two questions assessing carrying a gun and carrying other weapons such as knives or clubs. The survey also looked at other indicators of violence, drug use, suicide plans or attempts, and being threatened with a gun at school.

Researchers found that 3 percent of students had carried a gun to school and that 14.1 percent had carried a knife or club to school. Gun carrying was associated with increased age; male sex; minority ethnicity; and earlier age of onset of cigarette, alcohol, marijuana, or cocaine use. Gun carrying also was associated with current use of alcohol or drugs. In addition, students who carried a knife or club were more likely to carry a gun, be threatened with a weapon at school, and be involved in fighting.

The researchers conclude that school-based prevention programs targeting both violence prevention and substance abuse should be introduced in elementary school.

DuRant RH, Krowchuk DP, Kreiter S, et al.: Weapon carrying on school property among middle school students. *Archives of Pediatric and Adolescent Medicine* 1999; 153:21-26. For reprints, contact Robert H. DuRant, Ph.D., Department of Pediatrics, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 25157-1081; e-mail: rdurant@wfubmc.edu.

Recommended Reading

UNDERSTANDING TEMPERAMENT STRATEGIES FOR CREATING FAMILY HARMONY — *L. Shick. Seattle, WA: Parenting Press. 123 pages, $13.95 (paperback), 1998. (800) 992-6652.*

THE CRADLE OF KNOWLEDGE: DEVEOPMENT OF PERCEPTION IN INFANCY — *P.J. Kellman, M.E. Arterberry. Cambridge, MA: The MIT Press. 369 pages, $37.50 (hardcover). (800) 356-0343.*

SCHOOL VIOLENCE INTERVENTION: A PRACTICAL HANDBOOK — *A.P. Goldstein, J.C. Conoley (Eds.). NY: Guilford Publications. 480 pages, $55 (hardcover), 1997. (800) 365-7006.*

END THE GROCERY STORE WARS

Busy parents may not think of shopping for groceries as exciting, but a young child may see the supermarket as a wonderland of sugary cereals and shiny plastic trinkets. Does your child plead for treats and whine when you say "no"? Or does your child prefer the fall, kick and scream method of getting you to give in? Either way, chances are you both leave the store unhappy.

But shopping doesn't have to be a negative experience for either of you, if you agree on a policy and stick with it. Here's how.

Saying No

- ✓ Clearly establish the rule at home, before going to themarket: *"No asking for treats and toys when we shop."*
- ✓ Stick to the rule. It is fine to be flexible, but it's confusing and unfair if rules change too often. On occasion, a treat from the store can be used as a reward for earlier good behavior. For example, you may want to allow her to buy a treat because she did extra chores for you earlier in the day, but make it clear — before you enter the store — that the special treat is for the extra chores she did. Wait a while before you allow a shopping-trip treat as a reward again, so that she does not come to expect it or beg for it.
- ✓ As you enter the store, give your child a brief reminder. (Don't lecture!) *"Remember, Lisa, no asking for presents in the grocery store. The answer will be no."*
- ✓ After a few minutes of cooperation, reinforce her good behavior: *"Thank you for remembering the rule, Lisa."*
- ✓ Give her specific shopping tasks, constructive ways of getting your attention. Give her the choice among several cereals or have her select the number of oranges you need. She can count each potato as she drops it into the bag you are holding. Ask her advice in making such decisions as, *"The curly pasta or the wagon wheel pasta?"* If your child is older, let her help with the shopping by giving her a short list of items to retrieve.
- ✓ Sometimes you will not be able to take time to involve her. Let her know in advance if you are in a hurry. Tell her that this needs to be a quick trip. Say, *"Today we are in a big hurry. I will pick out the food, but you can help me push the cart."*

Sticking to it

- ✓ If your child starts to beg or fuss, tell her you're going to ignore her begging. *"I said 'no candy' and I'm not going to talk about it any more."* In a second or two redirect her attention by asking her which apples or bananas look best.
- ✓ If your child throws a full-blown tantrum, ignore it as if your life depended on it. Pretend that noisy character isn't your child. Walk a few feet down the aisle, but not so far that you scare her or appear to be running away from her. Read any labels you find in eyeshot. Or, if you are willing to admit parenthood to the curious onlookers, say *"The book I read said to ignore — not as easy as it sounds!"*

Continued, over ...

- ✓ Wait it out, staying calm no matter what she does. It will take only two or three successful bouts of ignoring for your child to get the message that Mom and Dad don't give in to screaming.

Keep helpful thoughts in mind while you are ignoring the tantrum:

- ✓ *I can outlast her, I can outlast her.*
- ✓ *This could be my last in-store battle.*
- ✓ *I survived labor; I can survive a tantrum!*

Be ready to praise. You never know when she will snap out of her tantrum. It gets pretty boring when no one is reacting. When she calms down, give some form of positive attention, like involving her again in the shopping. "Oh no, we forgot the dog food. Poor Custer! Help me find some." (Ignoring is not effective unless it is followed by positive attention.)

Ignoring is a very effective technique to reduce behaviors you dislike. When you ignore, you give your child two messages, "This is a behavior I dislike," and, "You'll get no payoff or attention from me as long as you continue."

Source: "The answer is NO: Saying it and sticking to it," by Cynthia Whitham, M.S.W. Los Angeles: Perspective Publishing, (800)330-5851. Adapted with permission.

The Brown University
Child and Adolescent Behavior Letter

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Resources

Sexual abuse information available

The National Clearinghouse on Child Abuse and Neglect Information, part of the Department of Health and Human Services in Washington, D.C., has many fact sheets and user manuals on the prevention and treatment of child abuse and neglect for caseworkers, caregivers, law enforcement officials and legal personnel.

For more information, contact the National Clearinghouse on Child Abuse and Neglect Information, 330 C Street, SW, Washington, D.C. 20447; phone: (800) 392-3366; e-mail: www.calib.com/nccanch.

Applications for fellowships now being accepted

The Center for Young Children and Families at Teachers College, Columbia University, New York City, is holding its sixth summer fellowship program for doctoral students. "Putting Children First," a fellowship training program in child and family policy with a developmental perspective, links academic learning across disciplines with interests in social policy. In cooperation with the Society for Research on Adolescence and the Society for Research in Child Development, the program has full-time placements for eight weeks in New York City government and nonprofit agencies. Fellows also attend weekly seminars at Columbia University's Center for Young Children and Families. The application deadline is April 3. Fellowships begin June 1. Fellows receive a $2,800 stipend and a $250 travel grant. Financial assistance is available for housing. To apply, send a three-page statement describing your interests in policy and research and a current resumé to Lisa O'Connor, Center for Young Children and Families, Teachers College, Columbia University, Box 39, 525 West 120th St., New York, NY 10027; or call (212) 678-3904.

AAP offers resource kit for substance abuse health

The American Academy of Pediatrics (AAP) in Elk Grove Village, Ill., has a "substance abuse health fair resource kit" available to schools and community organizations. Each kit contains 50 copies of brochures, fliers or posters on such topics as:

- The risks of tobacco use for parents and teens.
- Tips for parents on communicating with their teens about tobacco use.
- A review of the effects of marijuana and how parents can talk to their children about it.
- A review of the dangers of inhalant use.
- An explanation of the developmental damage that can occur to adolescents who abuse alcohol and drugs.
- Posters on tobacco and inhalant abuse.

The kits cost $35 each, which includes shipping and handling. For more information, contact the AAP Division of Public Education, P.O. Box 927, Elk Grove Village, IL 60009-0927; phone: (800) 433-9016.

Changes

from page 1

time spent in school, which rose from 21 to 29 hours per week, an increase of eight hours. As could be anticipated, the largest increase was in the time preschool children spent in school or child care; even so, school-age children also spent more time in school, presumably some before- and after-school programs are included by parents in their reports of "school time." An additional increase occurred in personal care time, which is time spent bathing, grooming and so on, but also includes time spent packing up one's possessions or getting ready to go places. Presumably spending more time out of the home entails more time getting ready to go as well.

Meal times also declined between 1981 and 1997, a decline of about an hour per week. This is consistent with increased maternal employment. There was a small, insignificant increase in time spent sleeping.

How free time has changed

Children spent about half of their free time playing and watching television in both 1997 and 1981. Given that free time declined, we would expect declines in most activities. Playing dropped by 25 percent, more than the overall decline in free time, and television viewing declined by slightly less — 13 percent. Churchgoing declined by 40 percent over the period and outdoors activities, such as walking, hiking and camping, declined by about 50 percent, though the times were not large to begin with. Finally, household conversations, that is, just sitting and conversing, declined by 100 percent over the period, though again, the initial numbers were small.

Children's time increased in several important activities, particularly sports, visiting, household work and other passive leisure. Sports includes standard team activities such as soccer, baseball, basketball and swimming. The time children spent in sports almost doubled over the period, from 2 hours and 20 minutes in 1981 to four hours and 20 minutes in 1997. Children participated in a wide variety of scheduled and organized sports activities in 1997. Participation increased equally for girls and for boys; still, in 1997 boys spent twice as much time in sports activities as girls.

Visiting increased by 200 percent over the period. This includes time spent on the telephone talking with friends. One puzzling finding was that time in household work more than doubled between 1981 and 1997. Finally, consistent with the conclusion that there has been an increase in structure in children's lives, we see that the time children spend in other passive leisure — going to shows and sports events at which the child is a spectator and not a participant — increased five-fold. In 1981, children spent one-half hour in other passive leisure; that figure was three hours and six minutes in 1997.

Implications

We recognize that families are a lot busier today; with two parents working and children in their own activities, even children need their own personal organizer. Family life requires very tight scheduling. The food preparation industry is a fast growing segment of the work force, with carry-out and restaurant foods substituting for home-cooked meals. Families may spend time running back and forth to stores rather than making goods at home. This is reflected in the increased time children spend in household work, the largest chunk of which is explained as time children spend accompanying parents on errands and shopping trips rather than traditional chores and cleanup.

Consequences

As the present generation of children moves into young adulthood, we may see the consequences in terms of their expectations of home and family life. Certainly, we are seeing in the overwhelming enrollments of young women in colleges and universities that women will be involved in careers in the future. Society will continue to adapt.

Television time has not gone up; in fact, it has declined, though not by as much as the overall decline in free time. Television is a passive activity that, overall, has a small but statistically significant impact on children's reading achievement test scores. On the down side, the total time spent reading — only about one hour per week — has not changed over the period. Of the activities we examined, reading is the activity that is associated with better reading comprehension and, therefore, with future success in school and life. While studying increased by 50 percent between 1981 and 1997, the total hours children spend studying is still small, only about two hours per week. In addition, studying is not necessarily associated with doing better in school because children who study more include those who are having school problems.

Finally, we did not find that children who spend less time playing at home necessarily do worse on tests of verbal or math achievement or have more behavior problems. Children may be playing in their preschool programs or have some free time at school. Thus, this study provides only a partial picture of children's time.

In addition, we found no evidence that mothers who work outside the home are neglecting their children. A difference of only three hours per week in direct parental engagement with children was found in two-parent families with an employed mother compared to two-parent families in which the mother was not employed.

There is one cautionary note. We found that children who spend fewer hours eating meals have higher levels of aggressive behavior problems than those who spend more hours eating meals. We do not yet know, of course, which comes first; however, meal time is an important time when children and parents can find out what happened over the day. This is not the only time children and parents spend talking, but since just sitting and talking as the main activity also declined dramatically between 1981 and 1997, there may be a basis for concern.

We will be conducting additional analyses over the next few years and conducting a second wave of data collection on these same children and their families in the year 2001. For more information on the Child Development Supplement to the Panel Study of Income Dynamics or to order a copy of our reports please visit our Web site at www.isr.umich.edu/src/child-development/home.html. ■

Sandra L. Hofferth, Ph.D., is a senior research scientist at the University of Michigan's Institute for Social Research. She may be reached at (734) 647-4575.

Counseling sex offenders

from page 1

acteristics of adolescent male sex offenders offer clues to the most important aspects of their misbehavior, namely, the ways they think about themselves and others, their perceptions of how to behave and their attitudes toward responsibility.

Some of those characteristics include obsessive thoughts about sex, feelings of inadequacy masked by arrogance and confidence, a need for adventure which is usually opportunistic and frequently illegal, an urgency for power and control, a primitive conscience, if any, and poor social skills. The offenders may have been emotionally, physically or sexually abused, but not necessarily. Other contributing factors to the profile might be a transient and/or dysfunctional family, poor school performance, poverty, lack of role models and use of alcohol/drugs, but again, these are not *necessary* contributing factors.

Psychiatric diagnoses for adolescent male sexual offenders run the gamut of conduct disorder, poor impulse control, antisocial behavior, aggression, dysthymia, depression, and a tendency towards affective and personality disorders (particularly borderline). One or several of these is always combined with their most outstanding feature, that of cognitive distortions that enable the offender to perceive their world much differently than their non-offending peers.

Prominent "thinking errors"

Of the 52 cognitive distortions, or "thinking errors," established by Samuel Yochelson and Stanton Samenow in their seminal trilogy, "The Criminal Personality," three, for the purpose of this article, are prominent.

1. Adolescent sex offenders behave morally and accept personal accountability only if it serves their purposes. Therefore, they think that lying, cheating and blaming others are legitimate ways to defend their inappropriate behaviors (for example, "If my mother hadn't allowed my sister to run around the house in her underwear, I wouldn't have molested her."). Typically, they refuse responsibility for their choices, and they might deliberately seek negative attention in their hunger for recognition.
2. Adolescent sex offenders consider themselves unique in the sense of being above society's rules. In fact, they make their own rules. Their pride in being "one of a kind" drives them to demonstrate their need for domination constantly. Inflated ideas of their own knowledge and expertise encourage primitive and impulsive decision-making, based on rumor, misinformation and myths.
3. Adolescent sex offenders exhibit twisted values as related to morality, for example, it is better not to get caught than not to perpetrate in the first place. They may be aware of the "Golden Rule," but that credo becomes, "Do unto others before they do unto you." They are extremely sensitive and bitter about pain caused to them, but empty and remorseless about pain they cause.

The therapist's task

To prevent another occurence of the crime, the therapist's first task is to slow the offender's thinking in order to identify and correct thinking errors. Treatment must offer appropriate information about sexuality, relationships, values and morality, and clients must be encouraged to internalize and practice the new information with the goal of increasingly more appropriate behavior. Counseling should develop a moral base that will gradually lead to an emerging conscience. Social skills must be sharpened to bring the client up to age level. Empathy, remorse, new coping skills must be developed while exploring the offense cycle and ways to implement the prevention of reoffending.

The foregoing tasks represent the bare bones of treatment. Many other needs of adolescent sex offenders reveal themselves throughout treatment, including therapy for victimization of some clients. Research suggests that optimal treatment occurs in a structured environment through multiple group experiences, and at least weekly individual counseling. Logical consequences must guide discipline, with constant repetition of morality lessons and reminders of legal issues. In essence, clients must learn to take responsibility for their own behavior and make connections between experience and learning.

Adolescent sex offenders can change if they wish to do so. If they choose not to change, they endanger all of society. ■

Joyce F. Lakey recently completed almost 12 years of working with adolescent male sex offenders in a residential setting. She has presented workshops on treatment and continues to write professional articles. She may be contacted at 3121 Oak Street, Terre Haute, Indiana, 47803; phone: (812) 232-6656.

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For more information about a story in the newsletter, or to send press releases, contact Linda Watts Jackim, Senior Managing Editor, *The Brown University Child and Adolescent Behavior Letter*, 208 Governor Street, Providence, RI 02906; phone (401) 831-6020; fax (401) 861-6370.

Commentary

Prescriptive child rearing

Recently I have paid a lot of attention to the contents of parenting magazines, in part because I have been spending a lot of time at airports. Browsing in the magazine shops between airplanes can be a very edifying experience. What impresses me especially is that parents today know they are living in a volatile world and an era of fast cultural change. Judging from what I see in most magazines designed to help parents be parents, everyone must be looking for THE answer, a quick fix, a ready remedy, an all-purpose solution. Article after wonderful article tells you what to do, and gives you advice in the form of "bullets," posing as great shots at child-rearing. The messages are often neither clear nor consistent:

- Don't rush your kids through their childhood . . . *but*
- It's never too early to capitalize on a child's talents.
- Punishment humiliates your child . . . *but*
- Do let your child know you didn't like what he did.
- Lay the rules down for your adolescent daughter . . . *but*
- Be careful not to over-control your children.
- Tell your son his girlfriend can stay for the weekend . . . *but*
- Don't let your son change your moral behavior.

> *I believe there is an assumption out there that parents do not know what to do any more and must turn to authorities for their guidance.*

I believe there is an assumption out there that parents do not know what to do any more and must turn to authorities for their guidance. They grew up in what they acknowledge to be a "different time," and they believe that their own value system and set of morés may be suspect.

This lack of confidence in themselves (their "selves") causes them to look elsewhere for guidance, and they turn to the "authority" of the magazine and its editorial staff as the final arbiter of what is good and useful and safe in child-rearing.

But the magazines can't always be "right," either. Who decides who will be on the editorial boards and who will be the writers, for a magazine? If it appears that I am dirtying my own nest, so be it. However, I am secure in the knowledge that I *know* every person on the editorial staff of this newsletter, and in the fact that I get to see every issue of this newsletter that you readers see . . . before you see it.

But now you say, "So you are very happy with yourself, and think you have the right answers." I take that cautionary note very seriously. For I know that some of the best pediatricians and other child developmentalists in the country, when advising the U.S. maternal and child health bureau in the past, wrote in the popular childrearing bulletin of the time that if a child is found masturbating, his (sic) hands and legs should be tied to the sides of the crib to prevent its recurrence!

Advice to parents is culture-bound and contextual. What is good for the goose may not be good for the gander and what is relevant in Uganda or Michigan may not be for the District of Columbia. Individual differences in families and individuals abound. Thus, while there are some universally acceptable values to rear a child with—such as instilling a good self-concept and a feeling of responsibility—laying the foundation for a caring attitude towards others and oneself—the style in which this is done successfully may vary appreciably from one family to another, one culture to another, and even one child to another in the same family.

In browsing magazines at the airport, I have discovered that every parent today has to be a "fast read." That's a term that seems especially popular on Wall Street. For fast-reading parents, I have a few "bullets" of my own.

- Don't believe all the bullets you read.
- Remember that all kids are different, even in the same family, and that is the wonder of childhood—and of humanity.
- Don't treat children as if they are best treated by word-bullets. Treat them to constructive and sympathetic conversation.
- And finally, try not to get jerked around by bullets. ■

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Violence

Lost boys: Why our sons turn violent and how we can save them

By James Garbarino, Ph.D.

The morning after the school shooting in Jonesboro, Ark., in May 1998, my 16-year-old daughter sat at the breakfast table reading the newspaper. After she finished the detailed account of the attack by 13-year-old Mitchell Johnson and 11-year-old Andrew Golden on their school mates, in which four people were killed, she looked up and said, "I wonder who it will be in our school?" Her sense of vulnerability is shared by children and youth everywhere, by parents, teachers, and administrators throughout the country.

> ***Once they are "lost" this way they tend to form into ... peer groups that build negative momentum throughout childhood and into adolescence. This can be avoided.***

For the past 25 years I have been studying the problem of violence in the lives of children, youth and families in homes, schools, communities and war zones around the world. Most recently I have been interviewing boys incarcerated for committing crimes of lethal violence. As a result of my investigations I have drawn four conclusions about why boys (who commit more than 90 percent of all lethal assaults) turn violent and how we can save them. I hope these are conclusions that parents can use in their efforts to make schools and communities safer.

The first of these conclusions is that no matter how

(turn to 5)

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Vol. 15, No. 4 April 1999

Inside This Issue

What's New in Research:
Atypical neuroleptics may become first-line treatment for childhood disorders.
See page 2

Keep Your Eye On:
A study finds that condom availability fails to increase condom use.
See page 3

Report reveals a plague of systemic problems in juvenile dependency courts.
See page 4

Guest Commentary:
Raising a moral child.
See page 8

This month's client handout:
Teaching children about medicine

Child Psychopharmacology

Watch out for clonidine toxicity in children with ADHD

A state poison control center is reporting a marked increase in pediatric clonidine (Catapres) poisonings, and the problem is being linked to an increase in prescriptions for the drug in children with attention-deficit/hyperactivity disorder (ADHD).

George C. Rodgers Jr., M.D., Ph.D., F.A.A.P., medical director of the Kentucky Regional Poison Center in Louisville, says the number of reports called in to the center increased from 10 cases in 1990 to 65 cases in 1997, or a six-fold increase. A total of 285 clonidine toxicity cases were reported among children in the state from 1990 to 1997: 119 had to be admitted to the hospital, and 66 had to be admitted to an intensive care unit.

For some time now, clonidine has been used primarily to treat hypertension in adults, says Rodgers. About 10 years ago, articles started to appear in the psychiatric literature suggesting that the drug might have some value in treating children with ADHD. Then, Rodgers says, "About five years ago, we started noticing a lot more calls related to

(turn to 6)

The Brown University **Child and Adolescent Behavior Letter**

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor Emeritus of Anthropology, Brown University

Carol Landau, Ph.D., Clinical Professor of Psychiatry and Human Behavior, Brown University; private practice

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

Senior Managing Editor: Linda Watts Jackim
Copy Editor: Susan Farley
Executive Editor: Gary A. Enos
Consulting Editor: Robert B. Whitcomb
Production Editor: Helen Ebrahim
Publisher: Fraser A. Lang
V.P. Finance: Paul J. Maloney, CPA
V.P. Marketing: Betty Rawls Lang

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What's New in Research

Atypical neuroleptics effective in treating children

Some of the atypical neuroleptics may become the first-line treatment for childhood schizophrenia and pervasive developmental disorders, according to researchers who conducted an analysis of the literature on atypical neuroleptics in children and adolescents.

The investigators reviewed all clinical experience with atypical neuroleptics (also referred to as "antipsychotics") in children and adolescents that was published from 1974 to 1998. Relevant clinical data from an analysis of the published reports were collated by type of drug.

They found five blind placebo-controlled clinical trials of 105 patients, 24 open-label clinical trials of 387 patients, and 33 case series of 115 patients describing the use of neuroleptics such as clozapine (Clozaril), risperidone (Risperdal), and olanzapine (Zyprexa).

Some of the newer drugs were effective in treating children and adolescents with schizophrenia, bipolar disorders and pervasive developmental disorders. The most "convincing evidence" of their efficacy occurred with the treatment of clozapine for schizophrenia, the authors say. The atypical neuroleptics were used to augment the selective serotonin reuptake inhibitor (SSRI) antidepressants such as fluoxetine (Prozac), but their efficacy for that indication was "unclear," investigators report. However, risperidone appeared to have anti-tic qualities in children and adolescents with Tourette's disorder.

Toren P, Laor N, Weizman A: Use of atypical neuroleptics in child and adolescent psychiatry. *Journal of Clinical Psychiatry* 1998; 59:644-656. For reprints, contact Abraham Weizman, M.D., Director of Research, Geha Psychiatric Hospital, P.O. Box 102, Petah Tiqva 49100, Israel.

Adolescent depression predicts adult depression

Symptoms of depression in adolescence strongly predict an episode of major depression in adulthood, even among adolescents without major depression, say researchers.

The researchers examined the relationship between subclinical depressive symptoms in adolescence and major depressive episodes in adulthood. They assessed an epidemiologic sample of 776 young people who had received psychiatric assessments in 1983, 1985, and 1992. Among adolescents who did not meet the criteria for major depression, the authors estimated the magnitude of the association between subclinical adolescent depressive symptoms and adult major depression.

The investigators found that the symptoms of major depression in adolescence "strongly predicted" an adult episode of major depression. In fact, having depressive symptoms more than two standard deviations above the mean in number predicted a two-fold to three-fold greater risk for an episode of major depression as an adult.

Pine DS, Cohen E, Cohen P, et al.: Adolescent depressive symptoms as predictors of adult depression: Moodiness or mood disorder? *American Journal of Psy-*

chiatry 1999; 156:133-135. For reprints, contact Daniel S. Pine, M.D., New York State Psychiatric Institute, Box 78, 722 West 168th St., New York, NY 10032.

Cigarette use up among college students

"Cigarette use is increasing on campuses nationwide in all subgroups and types of colleges," say the authors of recent research. "Substantial numbers of college students are both starting to smoke regularly and trying to stop. National efforts to reduce smoking should be extended to college students."

The researchers designed their study to examine the changes in cigarette smoking among different types of college students and different colleges between 1993 and 1997. A total of 15,103 randomly selected students in 1993 and 14,251 students in 1997 responded to a self-administered survey from the Harvard School of Public Health College Alcohol Study. There were 116 nationally representative four-year colleges in the survey.

Students were asked about cigarette smoking in the past 30 days and in the past year, their age at smoking their first cigarette, and the number of attempts they had made to quit.

Between 1993 and 1997, the prevalence of current (30-day) cigarette smoking rose by 27.8 percent from 22.3 percent to 28.5 percent. The increase was noted in 99 of 116 colleges. Current smoking increased across all subgroups of students as identified by sex, race, and year in school, and in all types of colleges.

Smoking was found to increase at a faster pace in public schools (22 percent in 1993 to 29.3 percent in 1997) than in private schools (22.9 percent to 26.8 percent). After age 19, 11 percent of smokers reported they had their first cigarette and 28 percent began to smoke regularly. Half of the current smokers had tried to quit in the previous year, and 18 percent had made at least five attempts to quit.

Wechsler H, Rigotti NA, Gledhill-Hoyt J, et al.: Increased levels of cigarette use among college students: A cause for national concern. *Journal of the American Medical Association* 1998; 280:1673-1678. For reprints, contact Henry Wechsler, Ph.D., Department of Health and Social Behavior, Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115.

Keep Your Eye On

... teen suicides.

The parents of adolescent suicide victims are often unaware of warning signs such as depression and substance abuse, according to a recent study. Drew M. Velting, Ph.D., and colleagues at Ball State University investigated the psychiatric characteristics of teens who made serious but unsuccessful suicide attempts by comparing the teens' self-reported symptom rating to those obtained from parent interviews. They found that parents significantly underestimated their children's' major depression. Fifty-seven percent of the near-suicides had major depression, but only 13 percent of parents thought their children had major depression. In addition, researchers found that of the adolescents who attempted suicide, 47 percent had non-aggressive conduct disorder, but only 13 percent of parents thought their adolescents had the problem. (*American Academy of Child and Adolescent Psychiatry.* For more information, contact Maria Pasho at (202) 966-7300. E-mail: mpasho@aacap.org.)

... condom availability and increased use

A study at 10 Seattle high schools who made condoms available in health centers and vending zzmachines to reduce HIV, other STDs and pregnancy reports that these efforts failed to increase condom use, but also didn't increase the students' sexual activity.

Among Seattle high school students who reported having sex during the three months preceding the study, the percentage who used a condom the last time they had sex decreased over time from 57 to 51 percent, while the number increased 3 percent (from 53 to 56) nationally. The percentage of Seattle students who had ever engaged in sex fell from 46 to 42 percent, but increased from 49 to 50 percent nationally. Additionally, the total number of Seattle students who had sex in the three months preceding the study decreased from 32 to 28 percent, while there was only a slight change nationally. The researcher advise, "Before trying to make condoms

Correction

Last month in our "Keep Your Eye On" column, under **"...school isolation room"** (page 2), Constance Carmody was incorrectly identified as the principal of Epping Elementary School in Epping, N.H. In fact, Carmody is the principal of New Franklin Elementary School in Portsmouth, N.H. She was never involved in the time-out room situation at Epping Elementary, and was never demoted as a result of the incident.

available, schools should determine whether students already have ample access to condoms." (*American Journal of Public Health*)

... problems, reforms in juvenile courts

A U.S. General Accounting Office (GAO) report entitled *Juvenile Courts: Reforms Aim to Better Serve Maltreated Children* says that juvenile dependency courts are plagued with systemic problems that include a lack of cooperation between courts and child welfare agencies, and personnel and data management issues that hinder the courts' ability to keep a child's stay in foster care as brief as possible.

The report included an examination of specific state improvements under the federal Court Improvement Program, interviews with federal and state officials and experts on the dependency court process, and visits to five locations that are engaging in reform efforts.

The report divides these states' reform attempts into two categories: those that try to improve the operation and infrastructure of the courts, and those that target decision-making in individual cases. State and local officials interviewed for GAO's report named three factors necessary for the successful reform of juvenile dependency courts: judicial leadership and collaboration among child welfare system participants, available and timely information on current court operations and case proceedings, and available financial resources to initiate and sustain reform. (The GAO report may be ordered by calling (202) 512-6000. Request document HEHS 99-13. The report also is accessible on the GAO's Web site, at www.gao.gov.)

Resources

College offers courses to students with LD

Landmark College in Putney, VT, has developed a comprehensive program for high-potential students with dyslexia, attention-deficit hyperactivity disorder (ADHD), and other specific learning disabilities. The summer session starts June 17 and ends August 6. A full schedule includes three classes plus tutorial. Each class and tutorial meets five days a week for one hour and fifteen minutes. In addition to tutorial with a Landmark College faculty member, the daily academic classes include writing-based English, study skills focusing on information- and time-management strategies, and either mathematics or speech communications.

The academic level of work is determined by an evaluation of diagnostic needs, together with the results of placement tests. Summer courses are identical to the courses described in our catalog for the fall and spring terms. Almost all students enter at the non-credit level.

The total fee for the summer session is $7,878, which includes room and board. Tuition and fees may be tax-deductible as medical expenses for federal income tax purposes, although applicants should seek information from their tax advisors.

For more information, contact Landmark College, RR 1, Box 1000, Putney, VT 05346. Telephone: (802) 387-6718. Fax: (801) 387-6868.

NASP offers program on tolerance for students

The National Mental Health and Education Center for Children and Families, a public service program of the National Association of School Psychologists (NASP), has released its most recent publication entitled "Pathways to Tolerance: Student Diversity." The program is an information guide for parents, educators, administrators, pupil services providers, and policy makers. It demonstrates how schools can meet the educational and psychological needs of America's increasingly diverse student population.

Articles in the program include information on promoting and understanding the effects of culture, race, ethnicity, religion, gender, sexual orientation, disability, and language on students' learning and behavior. The articles provide practical approaches to promoting a safe learning environment for children.

For more information, contact Victoria Stanhope, NASP, 4340 East West Highway, Suite 402, Bethesda, MD 20814. Telephone: (301) 657-0270.

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Help your children understand their medicines

Teaching your children good health practices includes teaching them about medicines. The more they know about medicines, the more prepared they are for independent and responsible use as they get older. Children need to know about how medicines work in the body.

What do children want to know?

Children need to learn about medicines from trusted sources — parents, physicians or teachers instead of from advertisements in stores, publications and on television. As a parent, you can encourage your child to ask the doctors about medicines and help them prepare appropriate questions. For example:

What will my medicine taste like?

How will it make me feel better?

Will it be pills, liquid or shots?

When do I have to take it?

How long do I have to take it?

Does it have side effects?

WHY do I have to take it?

What you should teach your children to do:

- Take the right medicine, at the right time, in the right amount — *read the directions* with your child
- Take all of the medicine prescribed even if your child feels better. This is especially important when taking antibiotics.
- Encourage your child to tell you about any unexpected side effects or reactions so you can call a health care professional.
- Participate in health education activities that teach the principles of responsible use of medicine.

Parents and caregivers

Most of all, as a parent, set an example of proper and safe medicine use by taking them only when necessary, by treating medicines seriously, and by storing medicines out of reach and sight of young children.

Ten principles for teaching your children and adolescents about medicines

These principles are intended to encourage activities that will help your children, through adolescence, become active participants in the process of using medicines* to the best of their abilities. These principles do not specify children's ages as children of the same age vary in level of development, experience and capabilities.

1. Children, as users of medicines, have a right to appropriate information that reflects the child's health status, capabilities and culture.
2. Children want to know. Health care providers and health educators should communicate directly with children about their medicines.
3. Children's interest in medicines should be encouraged, and you should teach them how

Continued, over ...

to ask questions of health care providers, parents, and other caregivers about medicines and other therapies.

4. Children learn by example. Your actions should show children appropriate use of medicines.
5. You, your children and your health care providers should negotiate the gradual transfer of responsibility for medicine use in ways that respect your parental responsibilities and health status and the capabilities of your child.
6. Children's medicine education should take into account what children want to know as well as what health professionals think children should know.
7. Children should receive basic information about medicines and their proper use as a part of school health education.
8. Children's education about medicine should include information about their general use and misuse, as well as about the specific medicines the child is using.
9. Children have a right to information that will enable them to avoid poisoning through misuse of medicines.
10. Children asked to participate in clinical trials (after your consent) have a right to receive appropriate information to promote their understanding before assent and participation.

* Medicines include all types: prescription medicines, non-prescription medicines, herbal remedies and nutritional supplements, such as vitamins and minerals.

Adapted from U.S. Pharmacopeia's *Guide to Educating Children About Medicine*.

The Brown University **Child and Adolescent Behavior Letter**

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Lost Boys

from page 1

effective, motivated and attentive any of us is as a parent, our children go to school with boys who are lost and who have access to lethal weapons. Knowing how these boys reach this point and what we can do reclaim them empowers us to reduce the odds that they will commit acts of lethal violence. Thus violence prevention is everybody's business.

My second conclusion is that the problem of lethal youth violence usually starts from a combination of early difficulties in relationships that are linked to a combination of difficult "temperament" and negative experience. Every parent who knows children knows that children come equipped with different temperaments. Some are sunny and easy; others are stormy and difficult. Some children are easy to parent; others are very challenging. When it comes to developing patterns of aggression, some of the difficulties lie in being impulsive, emotionally insensitive, having a high activity level, being of less than average intelligence and being relatively fearless.

Early, continuous parenting education

These temperamental problems do not spell doom, however. What matters is how well the parenting and educational experiences of these children meet the challenges posed by their difficult temperaments. One way trouble can arise is when parents and teachers abandon these children by withdrawing from them in the face of their negative behavior. This pattern of response increases the odds that these vulnerable children will become increasingly frustrated and out of sync as they meet up with the challenges of paying attention in school.

Parent education starting before children are born and continuing through until adolescence is crucial for preventing violence.

Teachers need special skills, motivation

Once they are "lost" this way they tend to form into aggressive and anti-social peer groups that build negative momentum throughout childhood and into adolescence. This can be avoided. For example, research by Sheppard Kellam and his colleagues demonstrates that if the first grade classroom is well organized and provides clear messages about behavior, aggressive boys are reclaimed and their aggressive behavior tamed. If the classroom is chaotic, then these boys form negative peer groups and their problems with aggression intensify. Children whose difficult temperaments puts them on track for problems with aggressive behavior need help from parents and teachers to learn to manage their behavior.

Teachers need special skills and a high level of motivation to create classroom environments that prevent violence.

Research shows that patterns of aggression start to become stable and predictable by the time a child is eight years old: unless we do something to intervene, children identified as aggressive at this age will tend to be aggressive 30 years later (becoming adults who are violent in their families, get involved in fights in the community and drive their cars aggressively).

The maltreatment pathway

My third conclusion is that the most common pathway to this pattern of aggression at age eight is for temperamentally vulnerable children to be the victims of abuse and neglect at home and as a result to develop a negative pattern of relating to the world in general. This maltreatment can be both physical abuse (beatings) and psychological abuse (rejection).

The negative pattern that results has four parts: 1) being hypervigilant to the negatives (such as threatening gestures) in the social environment around them; 2) being oblivious to the positives (such as smiles); 3) developing a tendency to respond aggressively when frustrated; and, 4) drawing the conclusion that aggression is successful in the world.

According to research by psychologist Kenneth Dodge, Ph.D., and his colleagues, this negative pattern is the most potent link between a child being the victim of maltreatment and developing a pattern of chronic bad behavior and aggression (what will be diagnosed by mental health professionals as "conduct disorder").

Being abused produces a sevenfold increase in the odds of developing conduct disorder. About a third of these children with conduct disorder will eventually become violent, delinquent youth (and about 90 percent will go on to demonstrate some serious problem in adulthood). In juvenile prisons, typically about 80 percent will have shown this negative pattern.

Child abuse prevention is the cornerstone of preventing lethal youth violence.

The social environment

My fourth conclusion is that troubled lost boys will be as bad as the social environment around them. I have identified this as the issue of "social toxicity," the presence of social and cultural "poisons" in the world of children and youth, to which lost boys are especially susceptible. The glorification of violence on television, in the movies and in video games is part of this social toxicity, and it affects aggressive boys more than others.

The same is true for the size of high schools. Lost boys are particularly affected in a negative way by being in big schools (with more than 500 students grades 9-12). The availability of drugs and guns is another example. The shallow materialist culture in which we live, the culture that undermines spirituality, is another.

One way to deal with all these issues is to have schools join with community leaders to embrace the national character education campaign. This can provide a rallying point for improving the social environment.

Detoxifying the social environment of children and youth is essential to protect them from the problem of lethal violence. ■

James Garbarino, Ph.D., is co-director of the Family Life Development Center and professor of Human Development at Cornell University. This article is based upon his book, *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them* , which is to be published in May, 1999, by The Free Press (a division of Simon and Schuster), in New York. $25, hardcover. To order, call (800) 223-2348.

Clonidine toxicity

from page 1

young children getting into clonidine."

Overdose can cause serious problems

Clonidine toxicity is a serious complication for children, causing problems such as bradycardia, hypotension and respiratory depression, says Rodgers.

"The problem with clonidine is that unlike some of the other drugs used to treat ADHD, clonidine in very small doses in young kids has the potential to make them stop breathing," he notes. "These are very small tablets, and all it takes is one of these in a two-year-old to give that child a significant risk of having apneic spells and stopping breathing."

Most cases occurred in children ages one to three (99 cases); the next highest age group was seven to 10 years old, for 81 cases. None of the children died.

More than half (157) of poisonings occurred from a child's own medication, but 25 occurred from a sibling's medication, and 103 occurred from other sources, such as another relative.

"If you have a five, six or seven-year-old child at home who is receiving this as treatment for ADHD, there is a significant risk that younger siblings, or even the kid who is receiving it, may get into this in inappropriate ways," Rodgers adds. "A younger sibling picks up a tablet, gets into a bottle, or the child himself takes too much, and the risks are high enough that you have to put these kids in the hospital and watch them. Some of them end up in intensive care units getting intubated and so forth."

Clonidine has the weakest evidence to support its use in ADHD of all current drug therapies, says Stephen R. Saklad, Pharm.D.

Rodgers acknowledges that there are risks with any drugs prescribed to children, and that clonidine can be a valuable tool to help children with ADHD calm down and improve school performance. Nevertheless, its use should be carefully monitored by parents and other providers to prevent accidental poisonings.

Rodgers notes that if an ADHD child takes too much methylphenidate (Ritalin), usually he or she can be watched at home. But the same is not true with clonidine, especially for children under the age of five.

"There are two risks with this medication," he says. "One is that younger siblings will get into them. The other is the ADHD kids themselves [will take too much]. ADHD kids have a higher incidence of accidental poisonings. By nature, they're always into things. The basic problem is that this is a high-risk drug."

Other ADHD drugs less risky

Rodgers advises physicians who prescribe the drug to children to "strongly counsel parents about the risks of this medication and the safety measures that should be taken, particularly if there are younger siblings in the home. This is one that deserves special warning to parents."

Rodgers says he also is concerned that many prescribers such as pediatricians are unaware of the "toxic potential" of the drug in children.

"They prescribe it for an eight-year-old," he notes. "That eight-year-old's younger sibling gets one of these little dinky tablets and ends up overnight intubated in the intensive care unit. The [prescriber] doesn't hear about that. But we want them to know they should be warning parents about this, or maybe using another drug that doesn't have quite this toxic potential."

Not first-line agent

Clonidine has the weakest evidence to support its use in ADHD of all current drug therapies, says Stephen R. Saklad, Pharm.D., B.C.P.P. of the University of Texas Health Science Center at San Antonio. He suggests that clonidine is therefore a third- or fourth-line agent.

Clonidine is available in three tablet sizes: 0.1 mg, 0.2 mg and 0.3 mg, as well as in three transdermal patch sizes (0.1 mg, 0.2 mg, 0.3 mg). The patches, used every 24 hours, are not commonly used in ADHD, but they represent a way to have sustained drug levels and effects without having to give more than one dose a day.

"This is particularly attractive in ADHD patients, where the mid-day dose is stigmatizing since it has to be given by the school nurse," says Saklad, who is also editor of *Psychopharmacology Update*.[*] "However, the patches contain much more drug due to the transdermal dosage system and if eaten or otherwise tampered with, can release much higher doses."

Clonidine should be tapered before stopping the dosage, as rebound hypertension can occur if the drug is abruptly discontinued, says Saklad. "This will present acute problems in a suddenly non-compliant ADHD patient," he adds

"Clonidine is one of two possible treatments for ADHD that is not a controlled substance, the other is bupropion (Wellbutrin), making it an obvious choice for clinicians who do not have authorization to prescribe controlled substances," Saklad says. "Despite that advantage, clonidine is a dangerous drug in overdose or after sudden discontinuation and should be reserved for patients who have failed first-line agents such as methylphenidate (Ritalin), mixed amphetamine salts (Adderal), or bupropion." ■

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[*] *Psychopharmacology Update* is a sister publication of *The Brown University Child and Adolescent Behavior Letter*. For subscriber information, call Barbara Deekle, director of customer service at (800) 333-7771.

Recommended Reading

An astonishing number of volumes have been published recently on attention deficit disorder. Here are some of those recommended:

INTERVENTIONS FOR ADHD: TREATMENT IN DEVELOPMENTAL CONTEXT — *Phyllis Ann Teeter. New York: Guilford Publications, 1998. 378 pages, $40 (hardcover). (800) 365-7006.*

ATTENTION DEFICIT DISORDER: PRACTICAL COPING METHODS — *Barbara C. Fisher and Ross A. Beckley. Boca Raton, FL: CRC Press, 1999. 380 pages, $29.95 (hardcover). (800) 272-7737.*

ATTENTION-DEFICIT HYPERACTIVITY DISORDER: A HANDBOOK FOR DIAGNOSIS AND TREATMENT (SECOND EDITION) — *Russell A. Barkley. New York: Guilford Publications, 1998. 628 pages, $55 (hardcover). (800) 365-7006.*

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (2ND EDITION): A CLINICAL WORKBOOK — *Russell A. Barkley & Kevin R. Murphy. New York: Guilford Publications, 1998. 134 pages, $28.95 (paperback). (800) 365-7006.*

ADHD AND THE NATURE OF SELF-CONTROL — *Russell A. Barkley. New York: Guilford Publications, 1997. 410 pages, $40 (hardcover). (800) 365-7006.*

ADHD IN THE CLASSROOM: DIAGNOSIS AND TREATMENT — *Arthur L. Robin. New York: Guilford Publications, 1998. 461 pages, $64.95 (hardcover). (800) 365-7006.*

MANAGING ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN: A GUIDE FOR PRACTITIONERS (SECOND EDITION) — *Sam Goldstein & Michael Goldstein. New York: John Wiley, 1998. 876 pages, $75 (hardcover). (800) 225-5945.*

ADHD RATING SCALE - IV: CHECKLISTS, NORMS, AND CLINICAL INTERPRETATION — *G.J. Dupaul, T.J. Power, A.D. Anastopoulos, & R. Reid. New York: Guilford Publications, 1998. 80 pages, $35 (softcover). (800) 365-7006.*

Guest Commentary

Raising a moral child

By Margot Stern Strom

"How do you raise a moral child?" a friend recently asked. She is the mother of a young daughter. She is also the person to whom I turn when I want to focus my thinking. I was both honored and challenged by her question. If "moral children" are those who recognize and show interest in issues of fairness and justice and think deeply about their relationship to other human beings, then she directed her question to the right mother.

In thinking about the way my children learned about the world, my initial reaction was to credit TV. Daily visits to Mr. Rogers' neighborhood introduced my son to a community marked by kindness, fairness and civility. Adam, and later his sister, also visited Sesame Street regularly. There they encountered lessons about self and others and similarities and differences.

I also credit pre-school teachers who tapped my children's potential by taking their questions seriously. In doing so, they modeled how to engage a child in the real world and foster democratic values. It was a lesson reinforced by books like Selma Freiberg's *The Magic Years* and Haim Ginott's *Between Parent and Child*. They pushed my thinking about childhood beyond the milestones of physical changes to the potential for intellectual and moral growth stimulated and supported by adults. Freiberg's descriptions of what a child learns from a simple game of peek-a-boo hooked me on cognitive and moral development theory and encouraged me to attend more closely to my children's development.

By the time my son was entering adolescence, I was teaching middle school and studying moral education at the Harvard Graduate School of Education. There I attended my first workshop on the Holocaust. Each participant received a copy of a letter reprinted in another of Ginott's book. A principal, a Holocaust survivor, sent the letter to his staff at the beginning of every school year. In it he warned, "Your efforts must never produce learned monsters, skilled psychopaths, educated Eichmanns. Reading, writing, arithmetic are important only if they serve to make our children more humane." That confrontation with the history of the Holocaust marked the beginning of an engagement with a new set of teachers. It also led to the founding of Facing History and Ourselves, a nonprofit educational organization that helps educators and their students link history to ethics and understand the role of citizen in a democratic society. It grew out of the need to not only teach about the events that led to the Holocaust but also to engage adolescents in an educational process that honors both "head and heart" — a process that sparks the interest of adolescents and enlarges their thinking through content with a moral dimension.

Because adolescence is a time of major transitions, young people need to think about their ideas, become aware of their own development, question, and wonder. Facing History and Ourselves supports students as they learn to view events from differing perspectives, understand competing truths, and consider their own intentions as well as those of others. One student wrote: "I found my voice, my moral voice, because of our class. I had been so quiet when others were loud and I never felt like I had the right to speak or that I had anything to say, especially about things other people felt strongly about. That's all changed now. I am a different person. I know a lot about something and that something is connected to social justice. And a lot of this I discovered myself. It wasn't fed to me or laid out for me to memorize. The questions we took on helped to hear other voices and to learn from history and from ourselves."

Moral education requires more than thinking. According to philosopher Hannah Arendt, we must also provide opportunities to make judgments through the give-and-take of serious discussion. "Judging, unlike thinking, needs the presence of others whose perspectives must be taken into consideration. It requires the imagination to put ourselves in the place of another human being."

How do we encourage students to walk even briefly in someone else's shoes? One way is by providing an education that is informed by history and tested in conversations that expand their knowledge, challenge their thinking, and ultimately lead to informed action. It is a process that demands that each of us continue to pay attention to our children for they help to develop the moral child in each of us. ■

Margot Stern Strom is executive director of the Facing History and Ourselves National Foundation. She may be reached at 16 Hurd Road, Brookline, MA 02445-6919. Phone (617) 232-1595; Fax (617) 232-0281.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Two-Part Report

Autism and childhood schizophrenia: What is the relationship?

By Anne Brown, NARSAD

This month's focus is on the characteristics of autism. Next month's issue will discuss childhood schizophrenia.

Pervasive developmental disorders (PDD), such as autism and childhood schizophrenia, are major public health problems, with tragic costs to the individual, the family and the community. While classification systems have improved over the years and treatment options continue to expand as new agents are developed, the prognosis remains poor for children with these illnesses.

Autism and childhood schizophrenia have several overlapping features: both have biological causes with neurodevelopmental roots; both are very rare with their own genetic link; and both are frequently associated with birth complications.

Autism

In most cases, it is not very difficult to differentiate autism from childhood schizophrenia (see box, page 5). Autism usually begins before age two-and-a-half, while schizophrenia is rare before five and is uncommon before age 10. The autistic child will have prominent withdrawal, language retardation, and repetitive routines, while the child with schizophrenia will have delusions, hallucinations and thinking disorders. Children with schizophrenia may have a family history of schizophrenia, but autistic children almost never do.

Because autism-like behavior can also be observed in children with the fragile X syndrome (abnormality in X chromosome characterized by mental retardation), phenylketonuria (a metabolic disease

(turn to 4)

Vol. 15, No. 5 May 1999

Inside This Issue

Keep Your Eye On:
Community youth service programs have positive influence on sexual behaviors.
See page 2

More schools are targets of anthrax hoaxes.
See page 2

What's New in Research:
Young girls unhappy with their bodies frequently read fashion magazines.
See page 4

Guest Commentary:
Developing a sense of wonder in young children.
See page 8

This month's client handout:
How to talk with your kids about TV

Behavioral Issues

Antisocial behavior in girls persists into adulthood

Girls who evidence antisocial or delinquent behavior during their childhood and teen years are likely to have difficulty in multiple dimensions of adult life. This conclusion can be drawn from an extensive review of the literature on female antisocial behavior, comprised of 20 studies conducted between 1926 and 1996. A follow-up period from one to 41 years was included.

Although it typically has been assumed that antisocial behavior among girls is rarer than among boys and that it seldom extends into adulthood, the literature shows that girls diagnosed with antisocial personality disorder, conduct disorder or delinquent behavior (in early studies) continued to have problems in their adult lives. In particular, the research focused on eight dimensions, including:

1. **Mortality.** Girls who evidence antisocial behavior tend to have higher than normal mortality rates when compared with other women. Adult mortality rates, reported in ten studies, ranged from 6 percent to 11 percent, with most of the deaths occurring in early adulthood. The comparable

(turn to 7)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

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Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

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Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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V.P. Marketing: Betty Rawls Lang

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Keep Your Eye On

... community programs alter sexual activity.

A study involving 1,061 African American and Latino students at two middle schools in Brooklyn, N.Y., found a positive correlation between community youth service (CYS) programs, classroom health instruction and the sexual activity of these adolescents who are at risk for unintended pregnancy, HIV and other STDs. Some students participated in the Reach for Health classroom curriculum and the CYS program doing community service at nursing homes, health clinics, day care centers and senior citizen centers, while others took part in the Reach for Health curriculum only, or no program at all. The study concluded that students participating in the CYS program and Reach for Health classroom curriculum were more likely than the control group to report that they were sexually abstinent or that they always used protection when sexually active. Researchers also found that the positive effect on sexual behavior was weaker in the Reach for Health curriculum-only group. The authors of the study determined that "a growing body of evidence suggests the limitations of curriculum-only approaches in producing desired behavior changes." (*American Journal of Public Health*)

... PTSD after accidents.

British investigators report that one in three children who had been in road traffic accidents suffered from post-traumatic stress disorder (PTSD) when they were assessed six weeks after their accident. In a 12-month prospective study of 119 children ages five to 18 who had been involved in road traffic accidents, PTSD was found in 41 children (34.5 percent). The study was conducted at the accident and emergency department at Royal United Hospital in Bath, England. Investigators compared those children with 66 children who had sustained sports injuries; the incidence of PTSD in those children was only 3 percent. The investigators conclude that "the psychological needs of such children after such accidents remain largely unrecognized," and that clinicians should consider screening them for PTSD and possibly placing them in treatment. (*British Medical Journal*, December 12, 1998, pp. 1619-1623. Contact Paul Stallard, Ph.D., Clinical Psychologist, Department of Child and Family Psychiatry, Bath Mental Health Care Trust, Royal United Hospital, Bath BA1 3NG.)

... school anthrax hoaxes.

School officials in the Perris (Calif.) Elementary School District recently were sent a letter containing a small gauze swatch with brown specks on it, accompanied by a letter stating that the specks were anthrax. Although it was found to be a hoax, school officials had to call in law enforcement officials, a county hazardous materials team, and other officials when they received the letter. The 18 school employees who were exposed to the letter had to be quarantined for several hours. Similar hoaxes have happened elsewhere, such as Gilbert-East High School in Anaheim, Calif., and in 16 schools in Los Angeles County. Experts recommend that schools handle anthrax threats as they do other emergencies, such as bomb scares and fires, and to call police immediately and follow established crisis response policies. (*School Board News*, January 26, 1999, p. 7.)

... school drug tests.

The U.S. Supreme Court last week let stand an appellate court ruling that found unconstitutional a drug testing program in an Anderson, Ind., school district. The district in 1997 had adopted a policy requiring all students suspended from school for three days or more to take a drug test before returning to school. A freshman at Anderson High School who refused to submit to a drug test after a suspension for fighting challenged the policy in court.

A federal judge agreed with the school district's policy, but an appeals court ruled that the policy violated students' privacy rights because administration of the drug test did not require suspicion of drug or alcohol use. The school district appealed to the Supreme Court, which last week let the appellate court ruling stand without comment or dissent. In 1995, the Supreme Court ruled that schools may administer random drug tests to students who participate in athletics, and last year the Court let stand a policy allowing a school district to randomly test all students engaged in extracurricular activities. (*Alcoholism and Drug Abuse Weekly*, March 29)

Recommended Reading

Three much-awaited volumes have appeared from the laboratory of Harvard's Howard Gardner in the series, "Project Zero Frameworks for Early Childhood Education." Under the general editorship of Gardner, David Henry Feldman and Mara Krechevsky, these are very useful works for those interested in learning details of how Gardner's psychological theories of development and education were put into practice, first in the preschool and early elementary classroom, and then into the community. The program capitalizes on the view that there are multiple intelligences and that individuals learn in different ways. Gardner and his team are committed to developing educational environments that are rich in stimulating materials and activities. These volumes provide a history of the project, and how-to, hands-on instructions in making education work better for youngsters who come to their parents and teachers with distinctively different skills, attitudes and temperaments. The three-volume 1998 set is published by Teachers College Press. Call (212) 678-4149 for more information.

Volume 1: Jie-Qi Chen, Mara Krechevsky and Julie Viens. *Building on Children's Strengths: The experience of Project Spectrum*, 172 pages, $17.95 (paper), $36 (cloth).

Volume 2: Jie-Qi Chen, Emily Isberg and Mara Krechevsky. *Project Spectrum: Early learning activities*, 252 pages, $18.95 (paper).

Volume 3: Mara Krechevsky. *Project Spectrum: Preschool assessment handbook*. 248 pages, $18.95 (paper).

Sarajevo statistics foreshadow fate of Kosovo's children

A study of post-traumatic stress disorder (PTSD) in 791 children and adolescents ages seven to 15 during siege conditions in Sarajevo, Bosnia revealed that:

- Girls were likely to report more stress than boys. For example, when assessed about their experience of deprivation of water and shelter, the mean Impact of Event Scale was 23.6 for girls compared to 21.6 for boys.
- Of all the children 613 (85 percent) had experienced direct or indirect sniper fire, although there was no significant relationship between experiencing sniper fire and the development of PTSD symptoms.
- A total of 66 percent of children (521) had lost an immediate or extended family member in the conflict, and those children had more symptoms of PTSD than those who hadn't.

Data were collected in February and March 1994 from all students in one school district. Children were assessed using the Children's Posttraumatic Stress Reaction Index and other scales.

The researchers conclude that "proximity to war atrocities and personal losses are highly correlated with the development of symptoms of PTSD." ■

For more information, contact Syed Arshad Husain, M.D., Department of Psychiatry and Neurology, School of Medicine, University of Missouri, Columbia, MO 65212.

What's New in Research

Media has major impact on girls' body image

The majority of the preadolescent and adolescent girls in a school-based study were unhappy with their body weight and shape, and this discontent was strongly related to the frequency of reading fashion magazines, say the authors of the study.

Researchers conducted a cross-sectional survey to assess the influence of the media on girls' weight concerns, weight control/loss behaviors, and perceptions of body weight and shape. The questionnaire assessed body weight, dissatisfaction with body weight and shape, exposure to fashion magazines, the impact of the media on feelings about weight and shape, attributes of and preferences for body types, and whether the girls had gone on a diet to lose weight or initiated exercise because of an article in a magazine.

The survey was completed in a mandatory physical education class in 548 girls in fifth through 12th grades in public elementary, junior high and high schools in Boston.

The outcome measures of the study were the perceived influence of fashion magazines on body dissatisfaction, the idea of a perfect body shape, dieting to lose weight, and initiating an exercise program.

Sixty-nine percent of the girls reported that magazine pictures influenced their idea of the perfect body shape, and 47 percent reported wanting to lose weight because of magazine pictures. In addition, there was a positive linear association between the frequency of reading women's magazines and the prevalence of having dieted to lose weight because of a magazine article, initiating an exercise program because of a magazine article, and other efforts to change their looks.

They attribute part of the problem with magazines presenting an unrealistically thin body ideal. Although they say it is "unrealistic" that overweight girls not be encouraged to lose weight, striving to look like underweight models should be discouraged. The authors recommend that print media aimed at young girls not use models who are severely underweight.

Field AE, Cheung L, Wolf AM, et al.: Exposure to the mass media and weight concerns among girls. *Pediatrics* 1999; 103:36-44. For reprints, contact Alison E. Field, Channing Laboratory, 181 Longwood Ave., Boston, MA 02115.

Autism
from page 1

characterized by an inability to oxidize phenylalanine and by severe mental deficiency), viral encephalitis (inflammation of the brain), and other diseases, autism appears to be a collection of diseases rather than a single disease.

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Autism can also accompany other illnesses. For example, epilepsy commonly accompanies autism; approximately one-half of autistic children may have some degree of mental retardation; and a higher than expected percentage of autistic children also have blindness or deafness.

In infancy, the symptoms of autism may be subtle and almost unnoticeable or optimistically disregarded by parents, but it is unusually clear by age two or three that something is wrong. Autistic children have little interest in others or understanding of their needs and feelings. They do not maintain eye contact and seem barely able to distinguish their parents from strangers.

As the children get older, they may panic at the slightest changes of a daily routine, throw screaming tantrums for no obvious reason, or strike themselves with their fists, they may even hit their heads against a wall, leaving parents and family members desperate for answers. While some researchers believe the disease may be a result of many different neurological malfunctions, others think the disorder is cognitive (i.e., the result of an inability to think in different ways).

Language development in autistic children is almost always slow. What first seems a "creative" choice of words turns out to be the beginning of abnormal linguistic patterning. Overall, they find it very difficult to sustain a conversation. Lacking an intuitive sense of human relations and social conventions, they cannot anticipate the thoughts and actions of others. They have an

HOW TO TALK WITH YOUR KIDS ABOUT TV

Developing visually literate, critical viewers

A suggested solution to the "television problem" — Just Tune It Out. We might wish our children would just do that, but television is a powerful medium. Through television a child can "go" to London before he or she can cross the street. Children are taught how to cross the street. They need to learn how to watch television. Thus, another way of addressing the "television problem" is to help children become visually literate, critical television viewers. A truly critical viewer will be a selective viewer.

The word broadcast indicates that television producers are looking for a wide audience for their programs. Children, on the other hand, have very specific viewing needs that change as they mature. Age-specific programs are aimed at a narrow child audience. For example, Teletubbies is aimed at toddlers. Barney, Mister Rogers and Sesame Street are aimed at pre-schoolers. Bill Nye the Science Guy targets the elementary school-aged viewer. It is important to let children know, early on, that some programs are intended for them, while others are not. Selectivity is the mark of a visually literate viewer.

Watch a child watching television. Some use television as "background." They do other things while watching. At the other end of the spectrum are those children who focus completely on the tube. One's approach to viewing begins early and probably continues through one's viewing life. Children who focus exclusively on the television may be "visual" learners who use visual material as a primary source of information. It is especially important that they develop looking skills, although all children really do need them.

Children can learn about television without specific lessons. A casual comment made while the child is watching is very important. How can we do this, and what do we say?

Name the program. "This is a news program. It will tell us about what happened today." "This is a game show. People are trying to win prizes." "This is a cartoon. It should be funny and make us laugh." "This is a soap opera. It is on every week day and tells a story that goes on and on." "This is a comedy, so it should make us laugh."

TV repeats and repeats and repeats... This is exactly what a young child loves. A child learns through repetition. This explains why a child will watch a program over and over. Each time something new is learned. It is helpful to know just what a child is learning. Note carefully programs that are especially lilted. Be sure the lesson being learned is in keeping with your family's values. But also comment, "You really like that program? Who are the characters? Tell me about ..."

TV's world is not real. While there is discussion of exactly what age a child is able to distinguish between reality and fantasy, very young children cannot make this distinction. Even children as old as six and seven can be confused. Early on you can begin pointing out methods used to give an illusion rather than being true to life — mention the laugh tracks; talk about actors and actresses; call attention to the music.

Children are often smarter than the people portrayed on television. By the time children are six or seven they are able to compare solutions they see on television with real life situations. This opens whole areas of discussion. During these discussions, if you listen more than you talk, you will have a window into HOW your child is thinking. This may be more important than WHAT your child is thinking. If you have concerns about your child's position, use this opportunity to discuss it. "The problem was solved by hitting that person. Was there another way to solve the problem?"

TV teaches children about people. Often the lessons are quite different from the experiences you want your children to have. Who are the "winners" and the "losers"? What is a victim? Who are heroes? What makes a hero a hero? What makes a "superhero"? How do the people on television look like people you know and how do they look different? Very young children need to be told about animated characters. "Arthur is a drawing." It will take a long time for a young child of three, four and even five, to both

Continued, over ...

recognize an animated character, and then understand what this figure is, i.e., a series of drawings. It is most helpful to compare the television character with the same character in the book version of the program.

Television is used to make money. The purpose of commercial television is not to entertain, not to educate but to make money. Somebody wants you to watch so you will buy toys, eat their cereal or buy their shoes.

Commercials are especially compelling. A lot of money is spent to attract the viewers' attention. Watch a toddler watching television. When a commercial comes on, she will stop and turn her full attention toward the television. This is exactly the time the child needs to know "This is just a commercial." Initially that is all that is needed, just the casual comment to the child. Each time a commercial airs and the child turns toward it, repeat the statement. Later add, "We are watching a commercial. The commercial wants us to buy something." Even later more information can be added: "This commercial wants us to buy (fill in the product name and perhaps a comment about the product)."

Children can learn, without direct lessons, to become aware of what they are watching and become both critical and selective about their viewing habits.

OTHER TOPICS TO BE CONSIDERED:

HOW TELEVISION MAKES ME FEEL

Television can affect how we feel after watching a program

1. Did the program make me feel happy?
2. Perhaps it made me feel sad. Why do we watch sad programs?
3. After a scary program, do you think about the scary parts? When?
4. Does television ever make you feel embarrassed, appalled, excited, sleepy? Can you think of some other words that describe how it makes you feel?

TIME FOR TELEVISION

It is not apparent to children that time spent doing one thing takes away from time to do other things.

1. Would you rather watch cartoons or play outside?
2. Would you rather talk to a friend or watch TV?
3. Do you like your favorite toy or the television best?

WHAT ARE THE CHARACTERS REALLY LIKE?

Often it is what is not shown on a television program that tells the most.

1. Why do you suppose people on television never watch television?
2. Why do people on television seldom seem to just have nothing to do?
3. What do you do that people on television never do?

By Mary Ann Banta, vice president, National Coalition on TV Violence

The Brown University Child and Adolescent Behavior Letter

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inability to make believe, which rests upon a fear that the world is ultimately chaotic, and their efforts to try and understand human interaction are met with frustration and futility. Consequentially, they are drawn to a state of rigid withdrawal for the purpose of simplifying experience in order to reduce terrifying confusion.

Asperger's Syndrome (AS)

Asperger's Syndrome (AS), more common in males, is often confused with autism, or thought to be a type of "high-functioning" autism. AS is characterized by an early period of fairly normal development without obvious delays in language, cognitive ability, self-help skills, adaptive behavior, or curiosity about the environment. However, impaired social interaction and restricted, repetitive patterns of behavior, interest and activities distinguish children with AS from the norm. Since these features are often first noted in the preschool years, this suggests a later onset than autistic disorder.

While there are large numbers of individuals who appear to have the symptoms of autistic disorder who can also be diagnosed as having AS (especially before age 10), researchers maintain that AS is indeed a distinct form of autism. One distinguishable factor is found in comparing verbal and nonverbal levels of intelligence, while higher functioning autistic children usually have nonverbal IQs that are considerably higher than their verbal IQs. Another noticeable distinction among the symptoms of both AS and autism is the degree of social awkwardness children show in group settings. Young children with AS usually do not give adults the impression that something is "seriously" different in their behavior as an autistic child does.

Brain abnormalities

Abnormal brain structures are prevalent in many autistic children. Researchers have also discovered that in autistic adults, the brain as a whole is larger than average and they are trying to find out where the extra tissue is concentrated. Imaging studies have shown small and densely packed neurons in the amygdala, the center for emotional responses to perceptual stimuli. Other studies have found low blood circulation in some parts of the cerebral cortex during certain intellectual processes and a reduced number of cells relaying inhibitory messages from the body movement centers in the cerebellum. It is unlikely, however, that any single region of the brain is responsible; the studies using autopsies and the latest brain scanning technology have eliminated the possibility that any one brain structure is to blame.

Genetic links

Like schizophrenia, the evidence that autism has biological causes has become overwhelming in recent years. The disease commonly afflicts identical twins, but rarely fraternal twins. Since identical twins share identical genes, and fraternal twins do not, the role of genes becomes undeniable. But it is difficult to study genetic transmission patterns since autism victims rarely have children. According to Joseph Piven, M.D., of the University of Iowa College of Medicine, there is a tendency for symptoms of autism to appear, in milder forms, in close relatives of an afflicted individual. Symptoms such as anxiety, aloofness, problems with communicating, poor reading skills, and difficulty interpreting the mental states of other people are more common than usual among close relatives of autistic patients. By studying patterns of symptoms, scientists may be able to locate which genes are responsible for the varying aspects of autism. However, there is little chance that a single gene causes the disorder. Recent studies show that no fewer than three genes generate the spectrum of symptoms displayed by autistic individuals.

One of the most interesting findings that may relate to the causes of autism is that mothers who give birth to autistic children report having had an unusually high frequency

How to differentiate autism from childhood schizophrenia

Autism:

- Usually begins before 2 1/2 years of age
- Prominent withdrawal, language, retardation and repetitive routines
- Half will be retarded
- Almost never have a family history of schizophrenia

Childhood schizophrenia:

- Rare before age 5 and uncommon before age 10
- Delusions, hallucinations and thinking disorders
- Few will be retarded
- May have a family history of schizophrenia

of bleeding during pregnancy, compared with controls. In addition to being found in retrospective studies, increased bleeding has also been found in a prospective study in which information was collected on large groups of mothers, and only later was the data analyzed on those who gave birth to autistic children.

Treatments

Christopher J. McDougle, M.D., of the University of Indiana, has found that a dysregulation of the brain chemical serotonin (5-HT) may contribute to the core clinical features of autism such as disturbances in social relatedness and communication, repetitive and ritualistic phenomena, and aggressive impulsive behavior. Moreover, McDougle's preliminary reports suggest that medications that facilitate 5-HT function may reduce certain disabling symptoms, such as social withdrawal, obsessive-compulsive behavior, and aggression in children and adults with autism.

As the autistic child gets older, a small percentage improves and functions well. The majority, however, take on the characteristics of adult schizophrenia, with an emphasis on "negative" symptoms (i.e., withdrawal, flattened emotions, poverty of thoughts), rather than "positive" symptoms (i.e., delusions, hallucination).

Medications

The effectiveness of drugs in treating autism has been disappointing. Almost all psychotropic medications have been tried to improve the developmental deficits associated with autism. Although no medication has been identified that fundamentally changes autism's core features, there are several groups of medications used to treat the symptoms of autism: antidepressants such as imipramine (Tofranil), desipramine (Norpramin), fluoxetine (Prozac), clomipramine (Anafranil) and trazadone (Desyrel); stimulants such as methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and pemoline (Cylert); neuroleptics (antipsychotics) such as haloperidol (Haldol) and thioridazine (Mellaril); and other drugs that come from various classes that are each used for different reasons, they are: carbamazapene (Tegretol), naltrexone (ReVia), fenfluramine (Pondimen), buspirone (BuSpar) and lithium (Lithobid and others).

Medications such as lithium and beta-blockers are often used for people with autism who are prone to violence to themselves or others. On the whole, however, conventional antipsychotics are often seriously sedative, and have serious side effects. Recently, studies have found that serotonin-enhancing drugs, fluvoxamine (Luvox) and clomipramine, reduce the repetitive body movements of autistic persons, and also help to minimize their compulsive ordering and arranging habits.

In most cases, neuroleptics such as haloperidol (Haldol), trifluoperazine (Stelazine) or pimozide (Orap) can result in behavioral improvement. Although few short-term side effects occur, studies have indicated that withdrawal dyskinesia develops in 25 to 30 percent of children, which thus causes concern regarding the possible development of tardive dyskinesia.

Behavioral therapy

Most parents of autistic children chose some type of behavioral therapy to work with their child. Behavioral therapists attempt to improve a child's deficiencies by classical conditioning (altering conditions or stimuli associated with the behavior in question) or operant conditioning (changing the consequences of a certain behavior with rewards and punishments).

Autistic children may have a serious lifelong disability. However, with appropriate treatment and training, some autistic children can develop certain aspects of independence in their lives. Follow-up studies of children with autism have found that only 5 to 10 percent become independent as adults, 25 percent progress but still require supervision, and the remainder continue to be severely

Subtle symptoms of autism in infancy

Autistic children have been reported as exhibiting subtle abnormalities in body movements as early as three months, according to a New York Times article.

Psychologist Philip Teitelbaum, Ph.D., a researcher at the University of Florida in Gainesville, reported preliminary findings that would allow diagnosis of the condition in babies whose brains are still developing at a rapid pace.

Until this discovery, most autism was not diagnosed until three years of age. Teitelbaum and other researchers believe that a reliable, early diagnosis of autism may lead to therapies that will "alleviate or eliminate the condition when the brain is its most malleable."

impaired and in need of a high level of institutionalized care. In addition to working with the autistic child, the child and adolescent psychiatrist or psychologist can help the family resolve stress — for example, a feeling among the siblings that they are being neglected in favor of the autistic child, or embarrassment about bringing their friends home. ■

Anne Brown is director of communications and education for the National Alliance for Research on Schizophrenia and Depression (NARSAD). She was assisted in this article by Rebecca Weaver who, at the time of this writing, was assistant director of communications and education at NARSAD. For more information, contact NARSAD at (800) 829-8289.

Antisocial behavior

from page 1

population-based death rates ranged from 1.1 percent to 7 percent. In addition, antisocial girls were significantly more likely to die violently than the population-based norm.

2. **Criminality.** Adult crime rates for women who were delinquent or antisocial as girls ranged from 10 percent to 96 percent. Cross-sectional studies of incarcerated women reported that 35 percent to 73 percent had been arrested as juveniles.
3. **Psychiatric morbidity.** Reviewed studies reported that fourteen to 96 percent of girls with conduct disorder had adult psychiatric problems, as compared with 0 to 40 percent of normal controls. Diagnoses included hysteria (21 percent to 40 percent); adult antisocial personality disorder (23 percent to 65 percent); substance abuse (40 percent to 70 percent) and depression (90 percent).
4. **Parenting behavior.** Women diagnosed with conduct disorder as girls were significantly more likely than normal women to have a family court record (33 percent vs. 4 percent of controls), to have children placed outside the home (36 percent), or to be unable to provide a safe, stable environment for their children (80 percent).
5. **Marriage.** Antisocial girls were more likely than normal controls to marry while in their teens (21 percent to 33 percent). They were also more likely to have marital problems; up 65 percent reported such problems, including being married to abusive or alcoholic men. The author reports that girls with conduct disorder at age 21 were "3.9 times more likely to have been involved in a mutually violent relationship" than normal or depressed controls.
6. **Education and occupation.** Antisocial girls were less likely than normal controls to complete high school or to have received any job training. They were significantly more likely than normal controls to be unemployed (15 percent vs. 0 percent) and to have held multiple, low-paying jobs (i.e., 10 jobs in 10 years).
7. **Service utilization.** Antisocial women had higher rates of service utilization than normal controls. They were more likely to need social services (55 percent vs. 10 percent) and to utilize physicians (23 percent vs. 10 percent).
8. **Global adult functioning.** Several studies found that antisocial girls were significantly more likely as women to have problems in two or more domains of adult functioning than were normal controls.

The adult course for adolescent girls with conduct disorder is not as benign as commonly assumed. Instead, such women have higher mortality rates, increased criminal behavior, multiple psychiatric problems, dysfunctional relationships, poor educational achievement and unstable work histories. ■

Pajer KA: What happens to "bad" girls? A review of the adult outcomes of antisocial adolescent girls. *Am J Psychiatry* 1998; 155(7):862-870.

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Guest Commentary

Developing a sense of wonder in young children

By Peter Ernest Haiman, Ph.D.

In recent years, the field of early childhood education, historically a field fully committed to *whole* child development, has focused primarily on cognitive and academic issues. From the point of view of the child, the most important dynamics of life and learning are emotional and social.

How can we, as parents and teachers, most effectively become the companions that help each child discover the joy, excitement and mystery of the world we live in? How do we make sure that our curriculum fosters and strengthens the sense of wonder in young children?

> *Wonder becomes possible when children can risk being themselves without there being any risk at all.*

The sense of wonder is an integral capacity of the newborn infant. It is possible when children are free from threats and fears. Here are some ideas of how parents and teachers can provide an atmosphere in which wonder can flourish in children. A sense of wonder is created, nourished and sustained when:

- Sensitive adults react in a prompt, responsible and satisfying way to the needs of their children.
- Parents lovingly hold and cuddle their child in ways and amounts that promote attachment, comfort and joy reciprocally between the parent and child.
- Parents and other adults close to the daily life of the child interact with the child and her world by expressing interest, spontaneous humor and joy.
- Parents and teachers encourage children to freely experiment, taste, feel, hear, see, explore and get into things that are interesting and safe.
- Children see and hear their parents and teachers become engaged and responsively enlivened when doing such things as reading a story and playing or listening to music.
- Children safely and playfully enact the stories in their imaginations or the imaginations of creative, empathetic parents and teachers.
- Children notice that their parents and teachers let themselves get lost in the fun and creativity of play.
- Parents and teachers find something good about the mistakes children will make as they grow and learn.
- Children in schools and preschools are influenced by educators who often ask, rather than teachers who usually tell.
- Teachers and parents are flexible enough to postpone their planned activities from time to time and let a child's creative idea or direction lead the way.
- Children are encouraged to voice their emotions and to talk about their hurts and fears with attentive, responsive parents and teachers.
- Young children can choose play activities based on their own feelings of interest and boredom and not the decisions of another person.
- The efforts of young children are regularly encouraged and prized. Children's sense of wonder is damaged and grows weak if their efforts are often met by adult corrections and criticism.

Wonder becomes possible when children can risk being themselves without there being any risk at all. ■

Peter Ernest Haiman, Ph.D., holds graduate degrees in educational psychology from Case Western Reserve University. He counsels parents with child/adolescent-rearing problems. He also works with adults in therapy. A version of this commentary previously appeared in *Young Children*, a publication of the National Association for the Education of Young Children (NAEYC).

The best time to solve young people's problems is before they happen

There's a lot of information floating around out there about what types of prevention programs have been tried and which ones work. The trouble is, until now, there has been no comprehensive resource to consult for answers. A new book — Prevention Programs for Youth: A Guide to Outcomes Evaluation, Best Practices, and Successful Funding — can give you the guidance you need. Priced at $69.95, this new guide is available by calling Barbara Deekle at (800) 333-7771.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Academic Performance

Achievement and motivation in poor and minority children

By Janine Bempechat, Ed.D.

The school achievement of poor and minority children has been an enduring puzzle to parents, educators and public policy makers. Barring severe learning disabilities or mental retardation, all children have the ability to learn, yet many are failing to reach their potential. Against this backdrop, those of us who study school success have noted with increasing interest the fact that there are many children who are at risk for school failure who are doing very well in school. They may live in poverty, or belong to ethnic or linguistic minority groups, or live in a single parent home, or have parents who are themselves not well educated. Yet something clearly is going on in these children's lives that is fostering achievement, while at the same time, so many of their peers are faltering. What is going on in the homes and schools of successful, "at-risk" students?

> ***Students who are lower achievers are at risk for embracing the belief that they lack ability.***

This was the question we addressed in a series of studies involving fifth and sixth graders in public and Catholic schools in and around the Boston area. With the participation of over 1,000 African-American, Latino, Indochinese and Caucasian children, we sought to understand their perceptions of the causes of success and failure, their views of the ways in which their parents try to fos-

(turn to 6)

PS 028191

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Inside This Issue

Solvent exposure poses risks in pregnancy. *See page 3*

A Guide to Safe Schools. *See page 4*

Dissociative disorder linked to physical/sexual abuse. *See page 5*

***Commentary:* Bewitched and bewildered.** *See page 8*

This month's client handout:
Use *CHOICES*, not anger, when dealing with conflict

Part-Two

Autism and childhood schizophrenia: What is the relationship?

By Anne Brown, National Alliance for Research on Schizophrenia and Depression

This is the second of a two-part feature. Last month's focus was on autism. This month we conclude with childhood schizophrenia.

Interest in childhood schizophrenia is mounting because of evidence that schizophrenia, like autism, has neurodevelopmental roots. Although childhood schizophrenia is an extremely rare disease with one in 10,000 children developing the illness, it has important implications for the understanding of schizophrenia at any age.

Because childhood schizophrenia is such an uncommon psychiatric illness, it is difficult to recognize it in its early phases. Only about 1 percent of all schizophrenia disorders manifest before age 10 and 4 percent before age 15.

Childhood schizophrenia can emerge as early as age five, though it is rare. From age 10, schizophrenia increases in incidence until age 15, when it begins a

(turn to 5)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

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Keep Your Eye On

... ADHD treatment.

Leading researchers in the field of attention-deficit/hyperactivity disorder (ADHD) in children are contending that medications such as methylphenidate (Ritalin) are underprescribed — not overprescribed, as many current news reports indicate. Josephine Elia, M.D., a child psychiatrist at the Children's Hospital of Philadelphia, and colleagues report that only about 4 percent to 5 percent of the estimated 10 percent of school-age children who have ADHD are receiving medication for the disorder. She says girls are especially likely to be missed, and that they are more likely to have the inattentive subtype of ADHD. Elia and colleagues note that both methylphenidate and dextroamphetamine (Dexedrine) are safe and effective for treating the disorder in children.

(*New England Journal of Medicine*, March 11, 1999. For a reprint, contact Josephine Elia, M.D., Children's Hospital of Philadelphia, Main Building, Room 366336, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399.)

... juvenile offenders.

Senator Paul Wellstone (D-Minn.) has introduced a bill that would mandate comprehensive mental health and substance abuse screening and treatment programs for youth in the juvenile justice system. According to Wellstone, more than one million children enter the justice system each year, and more than 100,000 youths are placed in some type of correctional facility. The National Mental Health Association (NMHA), which supports the bill, released results of a survey indicating that as many as three-fourths of youth in some juvenile systems have mental health problems, yet most do not receive treatment. In addition, the "vast majority" of the children are locked up for nonviolent offenses, says Wellstone.

"Many of these children are, in effect, dumped on the justice system because of cuts in mental health services in the community," he explains. "These children are overwhelmingly poor, a disproportionate number are children of color, and most come from troubled homes."

Wellstone advocates mental health treatment of incarcerated youth as a way to reduce recidivism.

(*American Psychiatric Association*. For more information, contact Public Affairs Department, APA, 1400 K Street, NW, Washington, DC 20005. Telephone: (202) 682-6324. The text of Wellstone's bill is available at www.thomas.loc.gov; search for the bill's number, S.464.-C.L.)

... child disability.

Brown University researchers in Providence, R.I., have received a grant from the National Institute of Child Health and Human Development (NICHD) to study the effects on families of raising a dis-

BEST COPY AVAILABLE

abled child and to determine whether government surveys accurately gauge those effects.

The five-year project is the first assessment of whether surveys mandated by the Americans with Disabilities Act of 1990 is gathering accurate results, according to Dennis P. Hogan, lead investigator and director of the Population Studies and Training Center at Brown University. Hogan says if the survey questions aren't sensitive enough, the researchers can make recommendations to the government about what type of questions should be on its surveys. The study will include 90 Rhode Island parents of children who were born prematurely. Parents will be asked about the effects of any disabilities on the family, such as a parent having to quit a job. Researchers also will analyze results from previous surveys of about 7,500 school-age children with disabilities about how their conditions affect their families.

Disabilities will be defined as functional limitations such as difficulty walking or eating. An estimated 20 percent of school age children are functionally limited themselves or have a functionally limited sibling.

(*The Brown University News Bureau.* For more information, contact Kristen Lans, The Brown University News Bureau, 38 Brown Street/Box R, Providence, RI 02912. Telephone: (401) 863-9595. E-mail: Kristen_Lans@Brown.edu.)

What's New in Research

Urine screening effective in detecting STDs

Researchers report that urine screening is the most cost-effective way to detect gonorrhea and chlamydia in asymptomatic adolescents, and the most likely to prevent the greatest number of cases of pelvic inflammatory disease (PID).

Researchers sought to determine the most cost-effective method of screening for chlamydia and gonorrhea to prevent PID in asymptomatic sexually active adolescent females. They used a cost-effectiveness decision analysis comparing pelvic examination with cervical screening, with a model of urine screening with ligase chain reaction testing for chlamydia and gonorrhea.

Among a potential group of 100,000 asymptomatic sexually active young women, four strategies using decision analysis were compared, using assumptions and costs generated from published data:

- Pelvic exam screening in 100 percent;
- Urine screening in 100 percent;
- Actual predicted pelvic examination screening in 70 percent;
- Actual predicted urine screening in 90 percent.

The cases of PID prevented per year and the cost to prevent a case of PID were the main outcome measures of the study.

With no screening, the results were that a total of 1,750 cases of PID would be predicted to occur per year. Using pelvic exams alone would prevent the most cases of PID (1,283) at an average cost of $10,230. Using urine screening alone would prevent 1,215 cases of PID at an average cost of $5,093. Using actual predicted pelvic exam screening would prevent 898 cases of PID, and predicted urine screening would prevent 1,093 cases of PID.

Shafer MB, Pantell RH, Schachter J: Is the routine pelvic examination needed with the advent of urine-based screening for sexually transmitted diseases? *Archives of Pediatrics* 1999; 153:119-125. For reprints, contact Mary-Ann B. Shafer, M.D., Division of Adolescent Medicine, Box 0503, University of California, San Francisco, CA 94143-0503. E-mail: shafer@itsa.ucsf.edu.

Solvent exposure poses risk in pregnancy

Women's exposure to organic solvents should be minimized during pregnancy, as symptomatic exposure appears to predict a higher risk for fetal malformations, according to research.

A prospective, observational, controlled study to evaluate pregnancy and fetal outcome following maternal occupational exposure to organic solvents was conducted at an antenatal counseling service in Toronto, Canada. The study evaluated 125 pregnant women who were exposed to organic solvents on the job between 1987 and 1996, and who were seen during the first trimester of pregnancy. Each woman

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who was exposed to organic solvents was matched to a pregnant woman who was exposed to a nonteratogenic agent, smoked and consumed alcohol.

The main outcome measure of the study was the occurrence of major congenital malformations.

The most commonly involved organic solvents were phenols, xylene, vinyl chloride, acetone and related compounds. The most common occupations were factory worker, laboratory technician, graphic designer and printing industry worker.

There were significantly more major malformations among the fetuses of women who were exposed to organic solvents than controls (13 vs. 1, relative risk, 13.0, 95 percent confidence interval, 1.8-99.5). Twelve malformations occurred among the 75 women who had symptoms temporarily associated with their exposure, but none occurred among women with no symptoms who had been exposed. Malformations included ventricular septal defect, prematurity, neural tube defect and congenital deafness.

"Occupational exposure to organic solvents during pregnancy is associated with an increased risk of major fetal malformations," the researchers say. "This risk appears to

A Guide to Safe Schools

In the wake of the Columbine High School massacre, many school administrators and counselors are looking for ways to prevent a similar tragedy from occurring to their students. The following is an excerpt from the U.S. Department of Education's pamphlet called "Early Warning, Timely Response: A Guide to Safe Schools." For further analysis, please turn to the Commentary *on page 8.*

Characteristics of safe schools

- *Focus on achievement.* Effective schools convey the attitude that all children can achieve academically and behave appropriately, while at the same time appreciating individual differences.
- *Involve families.* Schools must make parents feel welcome and keep families involved in their children's education.
- *Develop relationships among staff and students.* Some children need help overcoming feelings of isolation. Effective schools provide opportunities for adults to spend time with students and encourage students to help each other.
- *Discuss safety issues openly.* Schools can reduce the risk of violence by teaching children about the dangers of firearms, as well as appropriate ways to express anger and deal with feelings.
- *Treat students equally and with respect.* Students who have been treated unfairly may become scapegoats or targets of violence. Victims may react in aggressive ways.
- *Allow students to share their concerns.* Schools must create ways for students to safely report troubling behavior that may lead to violence.

Warning signs of violence

- *Social withdrawal.*
- *Excessive feelings of isolation.* Most children who appear to be friendless are not violent. But, in some cases, feeling alone is associated with aggressive behavior.
- *Excessive feelings of rejection.*
- *Being a victim of violence.*
- *Feelings of being picked on and persecuted.*
- *Low school interest and poor academic performance.* This can happen for many reasons; it is important to determine the true cause.
- *Expression of violence in writings and drawings.* Many children produce work about violent themes that is harmless. But an overrepresentation of violence that is directed at specific individuals consistently over time may signal problems.
- *Uncontrolled anger, expressed frequently and intensely in response to minor incidents.*
- *Patterns of impulsive and chronic hitting, intimidating and bullying behaviors.*
- *History of discipline problems.*
- *Past history of violent and aggressive behavior.*
- *Intolerance for difference; prejudicial attitudes.*
- *Drug and alcohol use.*
- *Affiliation with gangs.*
- *Inappropriate access to, possession of and use of firearms.*
- *Serious threats of violence.*

Use *CHOICES*, not anger, when dealing with conflict

We can't be effective parents when our anger overcomes our ability to reason. When that happens we are likely to yell, blame, threaten or use physical force. Or we make decisions by the seat of our pants, reverting to tactics we swore we'd never use on our children.

One parent said, "The stuff my parents did doesn't work with my kids. Sometimes I feel so helpless when I try to discipline them. When I'm on the spot, I just can't think of what to do. I usually end up getting mad and yelling my head off." As parents, we need to learn positive ways to respond to these potentially explosive situations.

The following ***CHOICES***, listed with their appropriate uses and limitations, will help you refine old strategies that don't seem to work and discover new and more creative ways of dealing with conflict and your kids.

Command

Give clear directions, specifically stating desired behavior in a nonhumiliating manner: "Stop hitting your brother *now*!"

> ***Uses:*** *Effective when immediate action is needed, when safety is an issue, or in establishing clear limits. It's important to follow through on limits you set in order for them to work.*
>
> ***Limitations:*** *May intimidate children so they are afraid to admit problems or to give you important information. Overuse may result in hidden resentment or rebellion.*

Humor or Surprise

Distract. Use nonsarcastic humor or do the unexpected to divert attention or diffuse an explosive situation: Channel kids who are bickering over a toy into a different activity.

> ***Uses:*** *When confronting is too dangerous or damaging, when an issue is unimportant, when a situation needs to be "cooled down," or when you need more time to prepare.*
>
> ***Limitations:*** *Issues may never get addressed.*

Offer Choices

Give a choice between two options: "You can ____ or ____" or "When you ____, then you can ____."

> ***Uses:*** *Helps child to make decisions within limits; helpful when children have few problem-solving skills.*
>
> ***Limitations:*** *Difficult when time or energy are too short for you to generate choices.*

Ignore

Choose not to address the conflict or unacceptable behavior by withholding attention.

> ***Uses:*** *When issue is unimportant or when power or attention are goals.*
>
> ***Limitations:*** *Issues may never get addressed. Unspoken assumption may be that behavior is acceptable.*

continued, over ...

Compromise

Seek a middle ground by finding a solution that partially satisfies both parties: "If you ____, then I'll ____."

> ***Uses:*** *When all else fails; for fast decision making on minor disagreements; when two parties are committed to mutually exclusive goals.*
>
> ***Limitations:*** *Losing sight of larger issues and values and possibly not pleasing anyone.*

Encourage Problem Solving

Work together to explore the disagreement, generate alternatives, and find a solution that satisfies the needs of both parties: "What can we do to meet everyone's needs?"

> ***Uses:*** *Learning from another's perspective; helpful when you need a decision that addresses the needs of everyone.*
>
> ***Limitations:*** *Not as helpful for minor decisions or when time is limited.*

Structure Environment

Rearrange people, objects or room structure to reduce conflict: Separate kids who are fighting in the car by moving them to different seats.

> ***Uses:*** *Useful when conflict can be reduced by moving people or things.*
>
> ***Limitations:*** *May only solve problem temporarily; doesn't involve children in addressing the issue.*

Adapted with permission from *Battles, Hassles, Tantrums and Tears: Strategies for Coping with Conflict and Making Peace at Home* by Susan Beekman and Jeanne Holmes, Conflict Management Consultants Inc. For more information or to order book, call toll free (888) 649-3040.

The Brown University **Child and Adolescent Behavior Letter**

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be increased among women who report symptoms associated with organic solvent exposure."

Khattak S, Moghtader GK, McMartin K, et al.: Pregnancy outcome following gestational exposure to organic solvents. *Journal of the American Medical Association* 1999; 281:1106-1109. For reprints, contact Gideon Koren, M.D., Division of Clinical Pharmacology and Toxicology, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, Canada M5G 1X8.

Dissociative disorder linked to physical/sexual abuse

While dissociation is trauma-related, it is neglect-related as well, say researchers.

In a study, 160 inpatients in a general psychiatric hospital were given the Dissociative Experiences Scale and the Structured Trauma Interview to determine the role of co-occurring childhood stressors and more chronic adverse conditions such as neglect. The study examined the level of dissociation in relation to childhood trauma such as sexual/physical abuse, early separation from a parent, and perceived parental dysfunction.

The average Dissociative Experiences Scale score was 17.4; 18 percent of the patients scored beyond 30. Early separation was reported by 26.4 percent of patients. Another 30 percent had witnessed interparental violence; 23.6 percent reported physical abuse and 34.6 percent reported sexual abuse.

The level of dissociation was primarily related to reported overwhelming childhood experiences, and when sexual abuse was severe, dissociative symptoms were more prominent. The highest levels of dissociation were found in patients who had cumulative sexual trauma such as intrafamilial abuse or both sexual and physical abuse. Maternal dysfunction was related to the level of dissociation as well.

These findings "imply the importance of object relations and attachment in the diagnosis and treatment of patients with dissociative disorders," say the authors.

Draijer J, Langeland W: Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients. *American Journal of Psychiatry* 1999; 156:379-385. For reprints, contact Nel Draijer, Ph.D., Department of Psychiatry, Vrije Universiteit, Valeriusplein 9, 1075 BG Amsterdam, The Netherlands.

Schizophrenia

from page 1

severe upward rise as it develops into the adult disease.

Boys usually are affected more frequently than girls before age 14, with about two boys being affected for every girl. Because of the broad criteria used for childhood psychosis, childhood schizophrenia often is grouped with childhood disorders such as autism and other major affective disorders. Consequently, it is often misdiagnosed.

Difficulty in diagnosis

The severity and frequency of hallucinations and delusions diagnose adult schizophrenia, but diagnosing children is much more difficult. There are few standardized rating scales for pervasiveness, and a variety of other severe psychiatric conditions of childhood can occur with schizophrenia. Children with schizophrenia also may use drugs or alcohol, have behavioral problems, severe depression, or neurological problems such as seizures and they are sometimes mislabeled with these conditions.

Unlike the usual sudden onset of psychosis in adults with schizophrenia, psychotic symptoms usually emerge gradually in children. Both early- and later-onset schizophrenics, however, experience symptoms associated with irregularities in autonomic nervous system arousal, difficulties in visual tracking of moving objects (smooth pursuit eye movement), and abnormalities of brain structure.

The behavior of children with schizophrenia may change slowly over time. For example, some children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. Sometimes youngsters will begin talking about strange fears and ideas. The child's teachers first may notice these early problems.

Neurodevelopmental damage

Neurodevelopmental damage seems to be greater in childhood than in adult onset type. Most children with schizophrenia show delays in language and other functions long before their psychotic symptoms (hallucinations, delusions and disordered thinking) appear, usually at age seven or later. In the first years of life, about 30 percent of these children have transient symptoms of pervasive development disorder, such as rocking, posturing and arm flapping.

Genetics

Like adult schizophrenia, childhood schizophrenia is believed to have genetic roots. Recent studies conducted at the National Institute of Mental Health by Judith L. Rapoport, M.D., found 17 percent of patients' families had first degree relatives with nonaffective psychotic disorders. Pregnancy and birth complications have also

Warning signs that a child may have schizophrenia

- Speech disturbances.
- Inability to distinguish dreams from reality.
- Confused thinking.
- Vivid and bizarre thoughts and ideas.
- Seeing and hearing voices that are not real.
- Extreme moodiness.
- Severe anxiety and fearfulness.
- Behaving like a younger child.
- Ideas that people are "out to get them."
- Severe problems making and keeping friends.

been found to be associated with childhood-onset schizophrenia. Both genetic and environmental factors are associated with the emergence of schizophrenia in adults.

Brain abnormalities

Imaging studies of brains of children with schizophrenia show some of the same abnormalities found in brains of adults with schizophrenia. In most cases, the child/adolescent with schizophrenia whose symptoms appeared before age 12 had a smaller cerebral cortex, enlarged ventricles (fluid-filled cavities), and smaller thalamus, which filters sensory input. The differences were about the same as those distinguishing adult patients with schizophrenia from healthy controls.

Treatment

Typically, the treatment of children and adolescents usually takes longer for adults because children and adolescents are still developing. Only 25 percent of patients with adolescent-onset schizophrenia achieve partial remission, while a chronic course is seen in about half of the afflicted youths. The prognosis is poorest for those with onset of the disorder before age 10 to 14 years and in patients with a family history of psychosis. A combination of medication and individual therapy, family therapy, and specialized programs (school, activities, etc.) often is necessary. Psychiatric medications monitored by a child and adolescent psychiatrist can be helpful for many of the symptoms.

Although children with the disorder are less responsive to pharmacotherapy than adults, standard antipsychotic drugs are usually effective. The use of olanzapine (Zyprexa) has been recently shown to be effective in managing severe, externalizing disruptive behaviors in a small study of developmentally disabled boys. This suggests there may be a role for olanzapine in children with developmental disabilities and accompanying difficulties in mood and behavior.

Clozapine (Clozaril) is especially helpful for those who do not respond to typical drugs, although children often endure more toxic side effects of clozapine than do their adult counterparts. ■

Anne Brown is director of communications and education for the National Alliance for Research on Schizophrenia and Depression (NARSAD). She was assisted in this article by Rebecca Weaver who, at the time of this writing, was assistant director of communications and education at NARSAD. For more information, contact NARSAD at (800) 829-8289.

Achievement and motivation

from page 1

aside, it is unfortunate that little is known about the achievement beliefs and attitudes of children ordinarily considered to be at risk for school failure. Unarguably, a large body of educational research is devoted to understanding school failure. By focusing on success, we believe that important lessons can be learned and applied to help all children reach their intellectual potential. Our research revealed findings that dispel the myth of poor parents as uninvolved in their children's schooling. To be sure, there were ethnic differences in actual mathematics achievement that mirror national data. That is, the Indochinese and Caucasian students did significantly better on the math test than did their Latino and African-American peers. More compelling, however, is that fact that within each group, lower achievement was associated with greater parental support and involvement in children's learning. This involvement was both academic and motivational. In other words, despite the fact that average math scores were very different between the groups, lower-achieving children in each group reported that their parents provided help with homework and emphasized the inexorable link between effort and good grades and between a good education and a secure and fulfilling future.

When we examined the students' beliefs about the causes of success and failure, we found that higher and lower achieving students held remarkably similar perceptions about their performance in school. Again, higher achievers believed that success in math was due to their ability, and failure was not the result of lack of ability. This is important because we know that when children believe that they have even some ability, it makes sense to them to invest effort in their learning. In contrast, lower achievers in each group believed that failure was due to lack of ability. This is problematic, because beliefs such as this leave children with the sense that they have little or no control over their learning. Within this framework, it makes little sense to try hard.

And what of the students in Catholic schools? Our results demonstrated a distinct motivational advantage associated with Catholic school enrollment. Relative to their public school peers, African-American and Latino students adhered to more positive beliefs about the causes of success and failure. Specifically, they were more likely to attribute success to ability, less likely to believe that failure could be due to lack of ability, and less likely to believe that success or failure could be the result of external factors such as luck or test difficulty.

Recommended Reading

Impulsivity: Theory, Assessment, and Treatment — *C.D. Webster & M.A. Jackson (eds). New York: Guilford Publications. 450 pages, $45 (hardcover), 1997. (800) 365-7006.*

Learning About Learning Disabilities (2nd edition) — *Bernice Y.L. Wong (ed). San Diego, Calif.: Academic Press. 754 pages, $59.95 (hardcover), 1998. (619) 231-0926.*

The ABCs of Learning Disabilities — *Bernice Y.L. Wong. San Diego, Calif.: Academic Press. 266 pages, $39.95 (hardcover), 1996. (619) 231-0926.*

Your Defiant Child: 8 Steps to Better Behavior — *R.A. Barkley & C.M. Benton. New York: Guilford Publications. 239 pages, $29.95 (hardcover), $14.95 (softcover), 1998. (800) 365-7006.*

Conduct Disorder and Under-Achievement: Risk Factors, Assessment, Treatment, and Prevention — *Harvey P. Mandel. New York: John Wiley. 292 pages, $65 (hardcover), 1997. (800) 225-5945.*

Understanding Elder Abuse in Minority Populations — *Toshio Tatara (ed). Philadelphia: Brunner/Mazel. 247 pages, $29.95 (softcover), 1999. (215) 269-0400.*

Implications

The most important implication of our findings is that, regardless of ethnicity, students who are lower achievers are at risk for embracing the belief that they lack ability. This poses a difficult challenge for teachers, for they need to communicate their belief that all children have the ability to learn, but will not be able to enhance or capitalize on their abilities without effort. One strategy may be to emphasize that what students perceive as innate ability or intelligence can only take one so far — that everyone, including those who are perceived as "smart," has to invest effort in learning in order to make the most of his or her skills.■

Janine Bempechat, Ed.D. is assistant professor in the Dept. of Human Development and Psychology at Harvard Graduate School. For more information, contact Dr. Bempechat by e-mail at janine_bempechat@harvard.edu.

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Commentary

Bewitched and bewildered

In our desperation to understand the seemingly inexplicable, the Littleton school massacre has become the focus of our bewilderment.

What seems to have monopolized the attention this time of the news commentators, as well as the social science and medical experts brought in on occasions like this, is that the usual explanations do not seem to be working for the Littleton tragedy. That's the problem with retroactive analysis.

As we now see, there were some "signs" that not all was going well in the lives of the two students who killed schoolmates, a teacher and then themselves. It is apparent, however, that none of those "signals" even in their aggregate was sufficient to energize an exceptional response from acquaintances and friends, their teachers, the police, and school counselors.

We will not have plausible causes until there is much more verifiable information about "what really was going on," precipitating this heinous attack on childhood buddies and adolescent peers. As individuals, the victims were virtually bystanders in relation to whatever was stirring the killers to murder other kids and destroy themselves.

The inevitable psychological autopsies are already occurring in which pieces of the puzzle are assembled. Some retrospective sense has begun to emerge. With the killers themselves dead, however, the opportunity is lost for a definitive analysis of the origins and "purpose" of this planned execution of young innocents.

The signals and signs of the killers' morbid dispositions have been the subject of many media treatments of the disaster of Littleton. That is always the way it is. To make sense of the unfathomable, we attribute telltale traits of the perpetrators, and call upon explanations in terms of adverse, or even traumatic, earlier experiences. This is the modern way. Psychological determinism and Freudianism are deeply ingrained now in our thinking about why people behave as they do.

A Vietnam veteran was executed recently at San Quentin for tormenting, brutalizing, raping and killing an elderly lady. Those seeking to prevent his death argued that he was made gravely vulnerable by his war experiences (which earned him the Purple Heart), and could not account for or even remember what he had done.

But thousands of other soldiers had terrible war experiences and have not killed anyone since coming home. Similarly, most people who own guns do not use them for murder — or indeed use them ever. Most adolescents who brood, or who wear black trench coats, or have body jewelry, or who are not doing well in school, do not kill or bully their schoolmates.

We clearly do not have as much behavioral research on "probable perpetrators" as we so obviously need. Even the constellations of signals and signs of adolescent trouble, recently gathered from therapists and social scientists and publicized by the media, do not serve accurately in forecasting serious crime because many people have fantasies (even of killing others!) that they never act on. Youngsters who are essentially normal have dark thoughts once in a while.

Occasions like the Littleton tragedy sensitize parents and teachers to the signs and signals that might forecast acts of violence. This often results in tagging individuals in whom the sign is there but signals nothing. The hazard is in the increasing possibility of false accusation, by innuendo if not action, of the suspect. It is the same curse of gratuitous prediction that lies behind race-generated anxieties and self-protective social interactions. Many black men, for example, notice with humiliation that white women hold their pocketbooks tighter when passing them on the street.

We are more sophisticated today at invoking presumed causes of mysterious and unpredicted behavior than in the not distant past when one could call upon "the witches" or unsubstantiated illnesses to account for the otherwise inexplicable. In the aftermath of Littleton, God's will or intent or eventually-to-be-revealed justification, were invoked repeatedly. The desperate call for explanation is always apparent in the midst of extreme loss.

If violence were a disease, we would have much more illuminating research going on to understand and prevent it. Tragedies such as muscular dystrophy, cancer or heart disease are not belittled when we recognize that, according to statistics from the Centers for Disease Control and Prevention, behavioral misadventures kill and debilitate more young people than all diseases combined.

The laws of behavior are binding. It is our knowledge that is uncertain or incomplete. We need to attend to that in order to improve the human condition.■

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Special Report: Anger

Anger springs from complex combination of traits, events

In order to respond to the increasing incidence of violence in children, we need to understand what causes a child's anger and develop ways to help them cope with their feelings. This issue's special report features insights and techniques for dealing with anger as described by Joseph W. Shannon, Ph.D., a clinical psychologist specializing in anger management. Shannon addressed an audience of 400 health care providers gathered at a "Mind Matters Seminar" in Providence, R.I., on May 14th. Reported by Fruma Efroom, Warwick, R.I.

While levels of self esteem, family experiences and the after effects of childhood abuse are important predictors of anger and depression in children and adolescents, these factors do not necessarily set up a direct cause and effect relationship, according to Joseph W. Shannon, Ph.D., a clinical psychologist specializing in anger management, who spoke recently at a "Mind Matters" seminar in Providence, R.I.

Shannon said biological and genetic factors, in particular, are important traits of temperament and play key roles. He noted nine inherited features that determine a child's manner or style of behavior:

- Level of physical activity and energy.
- Regularity or irregularity of physiological functions such as sleeping and eating.
- The tendency to approach or withdraw from novelty (introvert/extrovert).
- The capacity to adapt to new situations, people or places.
- The amount of stimulation needed to evoke a response to various stimuli.

(turn to 6)

Vol. 15, No. 7 July 1999

Inside This Issue

Maternal smoking may affect criminal behavior. *See page 3*

'Kids Have Stress Too!' program available. *See page 3*

12 reasons a child may want to join a gang. *See page 4*

***Commentary:* The wellsprings of anger.** *See page 8*

This month's client handout:
Tame temper tantrums with soothing solutions

Teaching children healthy responses to anger with assertiveness training

Joseph W. Shannon, Ph.D., recommends assertiveness training as an effective way to teach children to express and manage anger directed at others. He worries however, that neurological and psychodiagnostic testing is being underutilized in the treatment of anger. Anger resulting from biological and genetic factors is then underdiagnosed and treated ineffectively without appropriate medications.

Defining anger as an emotional, affective, antagonistic response to a situation, Shannon stated that anger is itself neither positive nor negative. "The problem is how we express it."

In discussing anger directed at other people, he outlined six patterns of response, five unhealthy and one healthy. The unhealthy responses were:

- Physically or verbally abusive behavior (aggressive behavior).
- Getting even (passive-aggressive behavior).
- Being a doormat (passive behavior).
- Projecting anger at another, safer target (displacement).
- Blaming other people (scapegoating).

"Some individuals may flip-flop

(turn to 4)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

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Keep Your Eye On

... pacifier use.

Early pacifier use among infants decreases breastfeeding duration in the first three months of life, according to investigators from Rochester (N.Y.) General Hospital. Results from a study revealed that women who introduced pacifiers tended to breastfeed their infants fewer times per day and reported that breastfeeding was inconvenient and that they had insufficient milk supplies. The researchers conclude that better education and support of breastfeeding women are needed to improve breastfeeding duration. (*Pediatrics* March 3, 1999. For a reprint, contact Cynthia R. Howard, M.D., Department of Pediatrics, Rochester General Hospital, 1425 Portland Ave., Rochester, NY 14621.)

... girls and affection.

The Ohio State University in Columbus conducted a study of adolescent girls and found them to be more helpful and affectionate toward their parents than adolescent boys. In addition, mothers receive more help and affection from their children than do fathers. The study involved questioning 129 children who were in the sixth, eighth, and tenth grades and their parents to determine how often the children helped their parents with tasks such as running errands, and how often they showed affection, such as giving hugs.

The study found that adolescents generally showed less affection as they got older. However, they showed more affection and consideration to parents when they viewed their parents as warm and supportive. The results of the study suggest that families may be teaching their children male and female gender roles for affection and helpfulness. For example, girls may have been more helpful than boys because many of the help-related activities in the study included traditional female tasks such as doing dishes and helping with the grocery shopping.

The researchers visited 129 families who participated in the study two times, one week apart. Parents and children completed separate questionnaires. Parents were asked to measure the frequency of helpful and affectionate actions by their adolescents. The quality of the relationship between the adolescents and their parents was correlated with the amount of affection and helpfulness the adolescents displayed. The results suggest that the best way for parents to encourage their children to be more helpful is to develop a close relationship with them, because adolescents will respond more positively when they feel supported and connected to their parents, says study co-author, doctoral student Mary Eberly.

"A lot of attention is focused on negative behaviors of adolescents," she says. "One of the good things about this study is that it allowed parents to focus on the positive things their children do." (*The Ohio State University*. For more information, contact Jeff Grabmeier, The Ohio State University, University Communications Office, 1125 Kinnear Road, Columbus, OH 43212-1153; phone: (614) 292-8457.)

... gambling among youth.

A review of the problem of gambling among youth indicates that of studies of 7,700 North American adolescents who gambled, there were three levels of gambling behavior severity. Although most youths had the lowest level of gambling severity, gambling on any level was still found to be associated with psychosocial problems. The lowest level of gambling, Level 1, reflects nonproblem social gambling and accounts for up to 83 percent of adolescents with gambling behavior. Level 2 is defined as "at-risk" or "in-transition" gambling, which accounts for up to 14.2 percent of adolescents with gambling behavior. Level 3 indicates there is a serious gambling problem or "pathological" gambling and accounts for up to 7.4 percent of adolescents with gambling behavior.

Problem gambling is associated with poor academic achievement, truancy, regular drug use, delinquency, aggressive behavior, stealing, drug sales, and prostitution. Most gamblers are male, and gambling is associated with a higher incidence of substance abuse disorders, comorbid psychiatric disorders, and suicidal behavior. Little research has been performed on the problem of gambling among youth; further studies need to be done on the problem, particularly in defining the magnitude of the problem, determining what causes the behavior, and its correlation with psychiatric disorders. Specific age-appropriate prevention and treatment plans also need to be developed. (*Psychiatric Services*, February 1999; 50:167-168. For more information, contact Vifrah Kaminer, M.D., Alcohol Research Center, University of Connecticut Health Center, 263 Farmington Ave., Farmington, CT 06030; e-mail: kaminer@psychiatry.uchc.edu.)

What's New in Research

Maternal smoking may affect criminal behavior

Researchers studied a group of 4,169 males born between September 1959 and December 1961 in Copenhagen, Denmark, and found a correlation between maternal prenatal smoking and criminal behavior in male offspring.

During the third trimester of pregnancy, mothers self-reported the number of cigarettes they smoked daily. When their male offspring were 34 years old, their arrest histories were checked in the Danish National Criminal Register. There were additional data collected on maternal rejection, socioeconomic status, maternal age, use of drugs during pregnancy, and other factors.

A dose-response relationship was found between the amount of maternal prenatal smoking and arrests for nonviolent and violent crimes. Maternal prenatal smoking was especially linked to persistent criminal behavior instead of to arrests that occurred during adolescence only. The relationship between prenatal smoking and criminal behavior remained significant even after potential demographic, parental and perinatal variables were controlled. The authors postulate that central nervous system damage may occur to the fetus when pregnant women smoke, which may later contribute to criminal behavior in their offspring.

"Maternal prenatal smoking pre-

Resources

'Kids Have Stress Too!' program available

A parent education program, Kids Have Stress Too!, has been launched by the Psychology Foundation of Canada in Toronto. The three-part series is designed to help parents better understand stress and help them teach their children ways to manage it. Developed with input from clinical psychologists, mental health workers, educators and child development experts, Kids Have Stress Too! includes a comprehensive manual and facilitator training designed to help professionals learn to deliver workshops to families in their communities or workplace.

The program is based on the premise that children lack the life experiences of adults and have few strategies to cope with stress and that children without strategies for dealing with stress may experience poor health, poor peer relationships, and difficulty in school. Using stress-management methods aimed at children can help them become more stress-resistant and help them deal with stressors more appropriately. Kids Have Stress Too! was developed by the Psychology Foundation of Canada, the Toronto Public Health Department, and the Toronto District School Board Stress Management Committee.

For more information, contact Elaine Bremer, Executive Director, Psychology Foundation of Canada, phone: (416) 595-9966.

dicts persistent criminal outcome in male offspring," the researchers conclude. "This relationship has not been accounted for by related parental characteristics or perinatal problems. Potential physiologic or central nervous system mediators between maternal smoking during pregnancy and offspring criminal outcomes need further study."

They also say their results underscore the importance of encouraging public health efforts to prevent smoking during pregnancy.

Brennan PA, Grekin ER, Mednick SA: Maternal smoking during pregnancy and adult male criminal outcomes. *Archives of General Psychiatry* 1999; 56:215-219. For reprints, contact Patricia A. Brennan, Ph.D., Department of Psychology, Emory University, 512 N. Kilgo Circle, Atlanta, GA 30322; e-mail: pbren01@emory.edu.

Healthy responses

from page 1

between two distinct patterns depending on their environments," Shannon noted. "They may be aggressive at school and passive at home or vice versa."

The one healthy response cited was the assertive model, which he sees as offering its users the greatest likelihood of getting at least part of their anger resolved. It is based on the principle that unhealthy ways of dealing with anger can be unlearned and healthy behaviors substituted. Shannon sees feeling anger as a facet of temperament that he defines as the inherited part of personality. He sees the expression of anger as largely a learned behavior with a biological basis within the limbic system.

Shannon attributes the skill deficits children have in expressing anger to poor role models. "Parents, parental figures, older siblings or people seen in the media may all be role models provided that the child has something in common with the role model and the child finds that person attractive," he said.

He acknowledges that no approach is appropriate in every situation or in dealing with every type of personality. "Assertiveness techniques would be highly inappropriate for a person attempting to survive an assault or rid themselves of a pest," he said. He also observed that narcissistic personalities respond very negatively to any confrontation technique.

The Assertive Model

This model uses the acronym DESK. "D" is describe the specific behavior that has angered him. "E" is express the feelings caused by that behavior using the "I message" as in "I feel unwanted and hurt whenever you speak to everyone at the lunch table except me." The "S" is state what the complainant wants the listener to change as in "I want you to remember to say, "Hi," to me when we all sit down. The final letter "K" is know that the listener may not change all or even any of his anger-provoking behavior. For maximum effectiveness, both the complainant and listener need to be trained in using the model.

Before starting, everyone is first advised to decide if the issue of behavior is even worth bringing up. Then, a convenient time should be set for a private discussion with

12 reasons a child may want to join a gang

- Gangs offer acceptance.
- Gangs offer belonging (affiliation).
- Gangs offer fun.
- Gangs offer love.
- Gangs offer emotional safety.
- Gangs offer power (control, potency).
- Gangs offer identity.
- Gangs offer respect.
- Gangs offer modeling.
- Gangs offer recognition (attention).
- Gangs offer success (competence).
- Gangs offer structure (standards, limits).

Gangs tend to be less attractive to a child who gets these needs met at home or in school. "The family has to be the better gang."

— Louis Gonzales, Ph.D.,
violence prevention specialist

From *The Parent's Little Book of Lists — DOs and DON'Ts of Effective Parenting* by Jane Bluestein, Ph.D. (Deerfield Beach, Fla.: Health Communications, Inc 1997); $10.95 (paperback). For additional information about Dr. Bluestein's programs and resources, call (800) 688-1960 or visit her Web site at www.janebluestein.com.

Tame temper tantrums with soothing solutions

Small children have temper tantrums for several reasons. They may have a basic need that isn't being met, or they have the goal of power, or they're testing limits, or they're simply frustrated. They communicate with the parent through a tantrum when they don't know any other way to do so, or when they don't want to communicate in another, more appropriate way.

One of the pitfalls in dealing with tantrums is that they conflict with our need to have things under control. We get angry with our children, and we want to quiet them as quickly as possible. What we need to do, instead, is take the time to figure out why the child is having a tantrum that we can meet his needs.

This chart will help you figure out what your child is communicating and what your most effective action will be:

If the Child is TIRED

What to do:

- Meet child's need.
- Minimize all talking that may lead to conflict.
- Hold or rock the child.

Example:

- Take child to bed or a quiet area to rest as soon as you can.

If the Child is HUNGRY

What to do:

- Meet child's need.
- Minimize all talking that may lead to conflict.

Example:

- Give child something to eat as soon as possible, even if it's not a scheduled snack or meal time.

If the Child is ILL

What to do:

- Meet child's need.
- Minimize all talking that may lead to conflict.
- Hold or rock the child.

Example:

- Give child medical assistance if needed.

If the Child is HYPERSENSITIVE

What to do:

- Remove object causing reaction as quickly as possible.
- Minimize all talking that may lead to conflict.

Example:

- If child's clothing is too tight, scratchy or hot, take it off as quickly as possible.
- If child is frustrated by abrupt changes, give advance warning or a choice. ("Tommy, we'll be leaving in 10 minutes," or, "Would you like to leave in seven minutes or 10 minutes?")

(Continued, over ...)

If the Child is TESTING

What to do:

- Do not give in.
- Bring child to self-quieting place.
- Leave the room. Do the unexpected.

Example:

- There are non-negotiable boundaries that you have set, and your child is testing you to see if you will hold the limits. You can discern this type of temper tantrum, because you feel manipulated.

If the Child is POWERLESS

What to do:

- Refuse to negotiate until child is calm and respectful.
- Acknowledge anger.
- Brainstorm solutions.
- Give child a sense of power.
- Fantasize with child about unfilled desire, if negotiation is impossible.

Example:

- "When you calm down, I am willing to discuss this with you," or "Please use your negotiating voice."
- "I understand that you are angry."
- "I want you to win, and I would like to win, too. How could we work this out so we both can win?"
- Together write on a sheet of paper all possible solutions.
- Ask yourself, "How can I give my child more power in an appropriate way right now?"
- "Yes, I would like ice cream, too. Two scoops with hot fudge, nuts, whipped cream, and a cherry on top. What would you have?"

If the Chlid is FRUSTRATED/OVERWHELMED

What to do:

- Are your expectations too high?
- Break tasks down into manageable steps.
- Make sure child knows how to follow the directions.

Example:

- If your child is having a difficult time getting homework done, break it down into ten-minute segments of homework followed by five minutes of play. Repeat cycle until homework is finished. Set a timer for each segment to make process easy to follow.

Adapted with permission from *Redirecting Children's Behavior* by Kathryn J. Kvols (Parenting Press, Inc. Seattle, WA) 1998. For more information or to order the book, call (800) 992-6657.

The Brown University Child and Adolescent Behavior Letter

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Academic Performance

Achievement and motivation in poor and minority children

By Janine Bempechat, Ed.D.

The school achievement of poor and minority children has been an enduring puzzle to parents, educators and public policy makers. Barring severe learning disabilities or mental retardation, all children have the ability to learn, yet many are failing to reach their potential. Against this backdrop, those of us who study school success have noted with increasing interest the fact that there are many children who are at risk for school failure who are doing very well in school. They may live in poverty, or belong to ethnic or linguistic minority groups, or live in a single parent home, or have parents who are themselves not well educated. Yet something clearly is going on in these children's lives that is fostering achievement, while at the same time, so many of their peers are faltering. What is going on in the homes and schools of successful, "at-risk" students?

Students who are lower achievers are at risk for embracing the belief that they lack ability.

This was the question we addressed in a series of studies involving fifth and sixth graders in public and Catholic schools in and around the Boston area. With the participation of over 1,000 African-American, Latino, Indochinese and Caucasian children, we sought to understand their perceptions of the causes of success and failure, their views of the ways in which their parents try to foster or encourage academic achievement, and the relationship of these perceptions to their achievement in mathematics.

Due to a production error, a segment of this article was omitted last month. It is reprinted in its entirety here. We apologize to you, our readers, and to Dr. Janine Bempechat, who authored the article, for the inconvenience.

— Linda Watts Jackim,
Sr. Managing Editor

Our choice of Catholic schools was not random. Educational researchers have known for some time now that poor and minority children in Catholic schools far surpass their public school peers on a variety of pre- and post-secondary outcomes, including grade point average (GPA), SAT scores, high school completion and college entry. These findings, however robust, are not free of controversy. Many have argued that Catholic schools, as schools of choice, may attract parents and children who are dedicated to educational pursuits. To the extent that this is the case, relatively little is known about the educational beliefs and attitudes of parochial school children and their parents. We hoped to shed some light on this issue.

Taking the issue of school type aside, it is unfortunate that little is known about the achievement beliefs and attitudes of children ordinarily considered to be at risk for school failure.

(Continued ...)

Unarguably, a large body of educational research is devoted to understanding school failure. By focusing on success, we believe that important lessons can be learned and applied to help all children reach their intellectual potential. Our research revealed findings that dispel the myth of poor parents as uninvolved in their children's schooling. To be sure, there were ethnic differences in actual mathematics achievement that mirror national data. That is, the Indochinese and Caucasian students did significantly better on the math test than did their Latino and African-American peers. More compelling, however, is that fact that within each group, lower achievement was associated with greater parental support and involvement in children's learning. This involvement was both academic and motivational. In other words, despite the fact that average math scores were very different between the groups, lower-achieving children in each group reported that their parents provided help with homework and emphasized the inexorable link between effort and good grades and between a good education and a secure and fulfilling future.

When we examined the students' beliefs about the causes of success and failure, we found that higher and lower achieving students held remarkably similar perceptions about their performance in school. Again, higher achievers believed that success in math was due to their ability, and failure was not the result of lack of ability. This is important because we know that when children believe that they have even some ability, it makes sense to them to invest effort in their learning. In contrast, lower achievers in each group believed that failure was due to lack of ability. This is problematic, because beliefs such as this leave children with the sense that they have little or no control over their learning. Within this framework, it makes little sense to try hard.

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And what of the students in Catholic schools? Our results demonstrated a distinct motivational advantage associated with Catholic school enrollment. Relative to their public school peers, African-American and Latino students adhered to more positive beliefs about the causes of success and failure. Specifically, they were more likely to attribute success to ability, less likely to believe that failure could be due to lack of ability, and less likely to believe that success or failure could be the result of external factors such as luck or test difficulty.

Implications

The most important implication of our findings is that, regardless of ethnicity, students who are lower achievers are at risk for embracing the belief that they lack ability. This poses a difficult challenge for teachers, for they need to communicate their belief that all children have the ability to learn, but will not be able to enhance or capitalize on their abilities without effort. One strategy may be to emphasize that what students perceive as innate ability or intelligence can only take one so far — that everyone, including those who are perceived as "smart," has to invest effort in learning in order to make the most of his or her skills. ■

Janine Bempechat, Ed.D. is assistant professor in the Dept. of Human Development and Psychology at Harvard Graduate School. For more information, contact Dr. Bempechat by e-mail at janine_bempechat@harvard.edu.

both parties are calm. The listener may not respond defensively even if he disagrees with what he is hearing. He should be empathetic to the complainant's feeling even if he is uncomfortable with the message.

Once dialogue has established that the complainant and the listener understand the issue, the two negotiate a settlement as in "I promise I will at least nod to you when we sit down." The complainant must then forgive the listener recognizing that he might not always remember to use the new behavior. Finally, the complainant asks himself what he has learned about both himself and the listener.

The roots of anger

Shannon sees anger as the most complex and confusing of all emotions. "Its positive effect of energizing behavior lends strength and determination to our efforts," he notes. "As tension is released, a warning is provided that a problem requires our attention. When we express anger assertively, but not disrespectfully, we feel good. We are empowered."

At the same time, prolonged or frequent anger can be physically harmful causing hypertension and lowering the body's immune system. It may lead to impulsive actions, impede our problem-solving abilities and harm others. "When we express anger using an abrasive tone and obnoxious words, we feel ashamed, guilty and regretful," he said. "We damage our credibility."

Shannon believes that ongoing research beginning with Papez in 1937 has conclusively demonstrated that the limbic system is the biological seat of emotion and anger. Stimulation and ablation studies in animals and humans have demonstrated that this system influences memory, learning, anxiety, rage, placidity and alertness, visceral and endocrine responses as well as behavior. It particularly influences aggressive, oral and sexual activity.

Research has not been successful at isolating individual parts of the limbic system and determining their specific functions. The system appears to operate as a whole with only the amygdala, hippocampus and uncus contained in the temporal lobe of the human brain. Chemical messengers within the limbic system such as serotonin, dopamine and norepinephrine affect mood as well as impulse control.

Outside of the limbic system, Shannon notes other biological processes, such as attention deficit disorder (ADD), that affect anger and impulse control. "While minor cases of ADD tend not to cause serious problems," he said, "75 percent to 80 percent of those prisoners incarcerated for violent crimes have moderate-to-severe ADD."

In addition, he notes that children with bipolar disorder (manic-depression) may experience violent episodes going in or out of their manic phase. Children with paranoid schizophrenia, a biological problem, also may become violent if they go off their medication. Finally, victims of early childhood trauma experience physiological changes to their brains that may affect impulse control.

Controlling problem anger

Shannon classifies anger leading to aggression or destructive acts as a problem. Other types of problem anger include anger that is too long lasting, too intense or too frequent. He points to four factors in understanding teenage violence: the child's neurological or biological predisposition; the child's relationship with his/her parents; the child's relationship with his/her peer group; and the extent to which the child engages in substance abuse. Assertiveness training addresses only the second and third of these factors.

Shannon believes that controlling anger is not the same as bottling it up and not expressing it. His first step in control is teaching children not to get angry in the first place. "If you can look at a situation differently, then you will feel differently about it," he said. "This approach represents the phenomenological point of view. At least part of every upset is the way a person views a situation."

Taking a cognitive approach, he trains people to become personal experts in their own anger. "They must look inside to learn when and in what situations they become angry," he advised. "They must ask themselves, 'Are you tired or hungry or overworked? Are you stressed? Are people unempathetic to your problems? Do they have unrealistic expectations of you? Do you expect everyone to love you and only good things to happen to you? Do you expect never to be inconvenienced?'"

Shannon advises that if anger is reality-based, keep it at a moderate level and express it constructively using assertiveness techniques. "Venting isn't enough," he notes.

Children need to be aware of how they express their anger and its impact on others. They should consider what their anger has cost them and what it has cost others, said Shannon. ■

Suggested Reading

Papéz JW: A proposed mechanism of emotion. *Archives of Neurological Psychiatry* 1937; 38:725.

Combination

from page 1

- The intensity of responses to stimuli.
- The quality of mood (pleasant to unpleasant).
- Distractibility.
- Attention span and the capacity to persist in spite of obstacles.

Shannon sees personality as the interplay of these nine traits and learned behaviors in about a 60 to 40 ratio, respectively, with a child's susceptibility to developing unhealthy anger stemming from this interplay. Outward signs of anger may not be true markers of the emotion of anger; rather, they may mask other emotions such as fear, and in turn, emotions like sadness may mask anger, Shannon said.

Childhood trauma

The age at which a child experiences trauma or abuse and the conditions under which the trauma or abuse happen strongly affect the child's potential for recovery. Abuse may arise both from within the family and the community from racism, bigotry or sexism.

"Children under age six abused by close family members, particularly parents, are at the greatest risk," Shannon said. He believes that even if that child is removed from the home and put into a sustained nurturing environment, his prognosis remains more uncertain. Physiological changes in the brain may occur that will permanently affect impulse control.

Shannon finds that abused children display the symptoms of post-traumatic stress disorder. Siblings who witnessed the abuse may also display similar symptoms along with survivor guilt. A gap in time may exist between the onset of symptoms and the original trauma. He notes that these children may also experience signs of general emotional numbing, diminished interest in life and a foreshortened sense of the future. "They are flat, apathetic, smiling depressives," he said.

Shannon agrees with Freud's characterization of depression as an internal temper tantrum. "Besides experiencing classic symptoms of depression including outbursts of rage and jumpiness, abused children may lose their sense of protection and experience betrayal and an overwhelming sense of helplessness," he said. "If the abuse came from a caretaker, they may repeat that abuse through inappropriate adult relationships that attempt to change the original abusive outcome to achieve feelings of worth and love."

'Besides experiencing classic symptoms of depression including outbursts of rage and jumpiness, abused children may lose their sense of protection and experience betrayal and an overwhelming sense of helplessness.'

Joseph W. Shannon, Ph.D.

He sees abused children chronically acting out or self-sabotaging. "They may develop suicidal ideation or behavior, psychosis and conduct disorders," he said. "If their abuse was sexual, the acting out may be sexual. One out of four women and one out of seven men were sexually abused before age 18. While 95 percent of these abusers are male, boys are as likely to be abused by a father or older brother as girls are. Sexual abuse is about domination, control and humiliating the victim.

Self mutilation

"Self mutilation in children and adolescents is generally a cry for help," Shannon said. In addition to the most obvious kinds of self mutilation, such as cutting, he said some extreme forms of tattooing, body piercing or branding also might be signs of self mutilation in some cases. "Early diagnosis is essential if self mutilation is suspected in children and adolescents," he noted.

As a first strategy, he advised talking to the child to determine his attitude toward his new permanent decorations. "It may only be a sign of a desperate attempt to fit in with his social peer group," he said. "In children and adolescents, self mutilation is an attempt to call attention to themselves or their family situation." Shannon recommended psychodiagnostic and neurological testing of a self-mutilating child as well as behavior modification therapy and medication. "The entire family system may need to be examined," he stressed.

Treating the abusive parent

In his experience, treating the abusive parents sometimes treats the entire family. "Many abusive parents have serious untreated emotional problems," he said. He estimates that 80 percent of abusing parents were themselves abused or witnessed abuse in the home. He further estimated that in 80 percent of abusive families, at least one parent was addicted to alcohol or some mood-altering chemical agent.

In working with these parents, Shannon expects to hear how awful the child is and how they deserve the punishments they are getting. "Abusive parents are experts at justifying their behavior," he said. "They have a narcissistic world view that treats the child's behavior as though it was intended to annoy them purposefully. They are inadequate in expressing their feelings, typically lacking warmth, humor and sensitivity to the needs and rhythms of their children. They project all their rage onto their children or onto one child."

Divorce

Divorce may not necessarily traumatize a child. "While the conventional wisdom is that children of divorce have more problems," Shannon said, "new research indicates that the relationship is not clear cut, particularly with regard to anger. Kids may develop problems because the parents stayed together. Some children report that they were relieved and emotionally better off following the divorce."

Shannon did not believe a child's age was an important factor in divorce. "Only if the kids are drawn into a power struggle between the parents, or if their standard of living drops dramatically after the divorce, or if communication between the parents and child is dysfunctional before, during or after the divorce are emotional and behavioral problems likely to arise," he said.

Self esteem

Self esteem is another equivocal area to Shannon. "If aggressive behavior is seen, don't assume the child has low self esteem," he warned. "The child may have a neurochemical imbalance or simply poor role models. The child might also be a bully with a grandiose perception of himself. Enhancing a bully's self esteem is like pouring gasoline on a fire."

He noted that the influence of peers and teachers becomes increasingly important factors in self esteem as the child grows older. "While more people have their self esteem devastated by their peers than by their siblings, the closer the family connection the more devastating the consequences," Shannon said.

In discussing the low self esteem child as an adult, he noted that self esteem is essential to intimacy, which he defined as an affirming relationship between two self-affirming people.

Shannon expressed concern that too much self esteem is building budding narcissists. "Children who are overindulged by at least one parent and who experience no healthy frustration are at high risk of becoming narcissistic," he said. "They will grow up believing that they should have everything they want and that the world should revolve around them." He sees children in day care as being at particular risk as guilty parents overcompensate by overindulging the child, particularly with respect to material objects.

Shannon is opposed to spanking even under very controlled conditions in a nurturing and loving home environment. He believes that Straus's research on spanking demonstrates that it may be fueling the very aggressive or antisocial behavior society is trying to curb. The effect holds across ethnic, racial and economic groups.

Treating anger

The differences in the way male and female children handle anger is another factor Shannon believes is fairly constant across societies. Male children externalize their anger by acting out, while female children internalize their anger by becoming anxious, depressed and socially withdrawn. Some internalize their anger through eating disorders.

In dealing with anger that does not involve another person, Shannon first tries to get the person to acknowledge or label their angry feelings. They ask themselves what the anger is all about — what they are thinking or believing. Talking about their anger with a friend or counselor allows them to get a different perspective on the situation. If their anger is linked to a particularly stressful situation, Shannon advises them to make a plan to alleviate that stress.

He recommends limiting techniques, such as catharsis and venting, to individuals who are neither borderline, psychotic or experiencing impulse control problems. He finds catharsis techniques such as yelling, swearing, beating a pillow or hitting a punching bag helpful for patients with good impulse control and patients who are too controlled. Even then, the catharsis is limited to specific activities for a brief structured time.

Shannon finds that aerobic exercise for 45 minutes three times a week helps some patients. He believes that a healthy diet and exercise lead to less anger and aggression.. ■

Suggested reading

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Commentary

The wellsprings of anger

Angry behavior is frightening. This is understandable, for angry behavior is frequently spiteful, hurtful and assaultive.

I believe that anger is present in babies, even newborns. One can tell from their intense reaction to pain, as when they scream and cry while getting inoculated. They become angry, also, when their breathing is occluded, even momentarily as when a blanket is pulled over their faces. They make tight fists, their muscles tense, and they pull their legs up to their chest. These are normal responses to threats to their well-being. The angry "fighting" message is there, in patterns similar to those found in angry adults on the verge of violence. The comforting hug of the attending adult is an important part of the process of anger-reduction, beginning in the newborn period.

Anger is frequently described as a condition or disposition, but when a person manifests anger there is almost always some eliciting or provoking stimulus. Much of the socialization is designed to get rid of the tendency of humans to lash out against conditions that hurt them.

> *Until we have a strong and enduring commitment to research anger and violence, we'll remain rather ignorant and, to an extent, helpless.*

Many lifelong patterns of angry behavior are acquired in the context of early experience. It is extremely important how the child is responded to when angry. These settings teach the child lifelong patterns either of adaptive or maladaptive ways of handling anger-provoking events. I am reminded of a cartoon in which an adult, presumably the parent, is shown spanking the child's bottom, and saying, "Here, this will teach you not to hit other children!"

Defensive behavior is as old as humanity, and indeed as old as sensate organisms have lived. Evolution seems to have protected those organisms that are best at defending themselves. This behavioral truth is of central importance in psychoanalytic theory as well; the psychological defense mechanisms, such as repression and denial, were said by Freud to be higher-order manifestations of the basic biological defenses against damage — against hurt.

Humans are born with defensive reflexes that are well designed for deflecting annoyances. Most newborn babies push objects away from their mouths and nostrils that threaten to smother, turn their heads away from noxious sounds, and close their mouths to toxic, bad-tasting substances.

Live organisms actively seek pleasant sensations and avoid or eliminate hurt. The higher we go on the evolutionary scale the more we see emotional reactions accompanying these approach and avoidance behaviors.

Just like the elementary aspects of social training, such as learning to use a toilet or to say "Please," most socialization results from the responses of one's family and community to socially unacceptable behavior. Our reinforcement or reward history shapes (for most of us, thankfully) acceptable social behavior.

Anger is more easily identified in the infant and young child than in the middle-school and adolescent child. This is why, so frequently, communities are stunned by unexpected violent events. Recent incidents of angry attacks by school children on others have highlighted the difficulty of identifying subtle anger so intense that the angry youth will plan precisely and secretly to kill others.

We have learned much about frustration and anger in the past several decades, but we're far from understanding this crucial aspect of development as well as we must. In our fast-changing world, the usual indicators of dangerousness are not stable, nor are the childhood indices of a disposition to hurt others very reliable. Until we have a strong and enduring commitment to research anger and violence, we'll remain rather ignorant and, to an extent, helpless. Moreover, until we have better techniques for unobtrusive and nonoffensive psychological monitoring, we will have unanticipated outbursts of a small number of individuals who will endanger the lives of others.

Surveillance of the psychological well-being of others can intrude on freedoms we cherish. There is no substitute for every child being born to parents who will cherish them. When anger-inducing conditions arise during the course of normal development, the child must be soothed by sympathetic, nurturing individuals who understand that life conditions sometimes cause hurt. ■

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Violence Prevention

Successful program goes beyond teaching social skills to addressing core attitudes toward guns, violence

By Jeremy P. Shapiro, Ph.D.

Rates of youth violence have escalated markedly in recent years. At the same time, our understanding of this problem has evolved; youth violence is no longer viewed simply as a crime requiring punishment but it is also seen as a mental health and developmental problem warranting intervention. During the past seven years, the Center for Research, Quality Improvement and Training of Applewood Centers, Inc. has conducted research in an effort to contribute effective assessment and intervention methods to the youth prevention field. Several tools have emerged from this work.

> ***Aggressive youth often find violence exciting, believe it provides power and safety, do not feel uncomfortable with its occurrence, and feel it is the only honorable response to disrespect.***

We developed an assessment instrument called the Attitudes toward Guns and Violence Questionnaire[1,2] that has produced new information about the psychology of violence. The instrument includes some focus on the issue of youth gun ownership, because involvement with guns is a marker of serious violence-related problems.

Factor analysis has indicated four major attitudinal components of attraction to guns and violence:

(turn to 5)

Vol. 15, No. 8 August 1999

Inside This Issue

Welfare reform plans that work. *See page 2*

Firearms commonly found in American homes. *See page 2*

Poll on spanking finds most are for it. *See page 3*

Adolescents abused as children behave differently than those with no history of abuse. *See page 3*

Major Depressive Disorder predicts higher rate of suicide. *See page 3*

Commentary:

Too much self-reflection yields too little insight. *See page 8*

This month's client handout:
Good books help children understand the problems of aging

Sex Education

Teen sex rates level off, but pregnancy and STD rates remain high

Teen sex is leveling off, according to data from the U.S. Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS), but American teens still have the highest rates of adolescent pregnancy and sexually transmitted disease in the developed world, according to John Santelli, M.D., M.P.H., F.A.A.P, of the CDC's Division of Adolescent and School Health. Speaking to the American Academy of Pediatrics in San Francisco, Santelli said, "There have been real changes in sexual mores. This generation of adolescents is more conservative."

According to the latest YRBS data, the proportion of high school boys who report ever having had sex declined by 15 percent between 1991 and 1997, while the proportion of high school females who ever had sex remained stable. Proportions of male and female high school students who had sex within the past three months, meanwhile, held steady at about 35 percent.

Condom use rose over the six-year survey period. In 1991, about half of high school boys said they used a condom the last time they had sex. In 1997, the ratio was

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The Brown University **Child and Adolescent Behavior Letter**

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

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Keep Your Eye On

... support in welfare.

Welfare-reform plans that include education, job training and high-quality day care for children offer the greatest promise of moving parents from welfare to work, a new study shows.

"Welfare recipients who received the highest levels of education, job training, and center-based child-care assistance had the highest levels of earnings, and their children had the highest scores on math and verbal achievement tests in middle childhood," says Hirokazu Yoshikawa, Ph.D., a psychologist at New York University.

He notes that welfare reform efforts have largely ignored children in the rush to move parents into the low-wage workforce.

"If one pays attention to children's outcomes, there are clear indications that some types of welfare reform efforts are better than others," says Yoshikawa.

Programs that focus on long-term rises in wages through education and other support services are more likely to benefit mothers and their children.

"Welfare reform packages should tailor their package of incentives and support services to match the needs of differing groups among the welfare population," he says. "Attention should be paid to the quality of nonrelative family day care, as the number of providers surges to meet new demands from child care voucher programs."

In data from 614 six- to eight-year-old children drawn from the ongoing National Longitudinal Survey of Youth, Yoshikawa found that children's verbal and math achievements tended to rise with increasing care in center-based daycare. Children cared for by nonrelated babysitters showed cognitive deficits compared with children in daycare. (*Child Development*, May 1999. For more information, contact Hirokazu Yoshikawa, Ph.D., at (212) 998-7826; e-mail: hiro@psych.nyu.edu.)

... firearms in the home.

In a survey of more than 5,000 U.S. households, the Centers for Disease Control and Prevention in Atlanta has found that one-third kept at least one firearm in the home and/or in a vehicle. Of those gun-owners, one in five have at least one firearm or keep at least one gun loaded and unlocked, and 30 percent store all firearms unloaded and locked. Almost half — 48.5 percent — stored firearms in a manner between those two practices — either keeping a loaded gun locked, or keeping an unloaded gun unlocked.

Households with children were more likely than households without children to store all firearms unloaded and locked (41.5 percent vs. 20.9 percent, respectively). Households without children were more likely than households with children to store at least one firearm loaded and unlocked (29.8 percent vs. 11.1 percent, respectively).

"These prevalence data show that children are potentially exposed to firearms in many households," the CDC researchers conclude. "This health threat illustrates the need for education about the issue of pediatric firearm injuries and for interventions to minimize associated risks. Health care providers should take advantage of opportunities to counsel patients regarding firearm safety in the home."

For example, parents should be instructed to keep firearms unloaded and locked, and to keep ammunition and firearms locked in separate locations. (*Archives of Pediatric and Adolescent Medicine* 1999; 153:586-590. For more information, contact Gail Stennies, M.D., National Center for Infectious Diseases, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, MS F22, Atlanta, GA 30341-3724. E-mail: GDS2@cdc.gov.)

... spanking.

A new national poll from the Children's Institute International (CII) in Los Angeles reveals that a majority of adults believe that children sometimes need a "good, hard spanking." The survey found that 82 percent of adults surveyed were spanked as children and that 55 percent believe spanking is necessary.

"It's worrisome that spanking remains such a part of the American culture, in view of scientific evidence demonstrating its ill effects," says Steve Ambrose, Ph.D., clinical psychologist and director of research at CII. "This suggests the need for continued public education. There is a wealth of research data showing that violent parenting produces violent children; so does negligent parenting. We are not saying parents shouldn't discipline their children, but there are more appropriate and effective ways than hitting them."

Although most of the people surveyed believed in spanking, most (60 percent) felt that if it left a mark, spanking constituted child abuse, and if a belt was used, 74 percent said it was child abuse. However, spanking was considered more acceptable at older ages. If it left a mark on a 12-year-old, spanking was accepted by 53 percent of people surveyed; if a belt was used on a 12-year-old, it was accepted by 54 percent of people surveyed.

There were some positive findings in the study. For example, only 8 percent of adults believed spanking was the best way to discipline a child. Alternatives, such as using time-out (19 percent) or removing privileges (19 percent) were preferred by some people who were surveyed. (*CII*. For more information, contact Wendy Root at CII by phone: (310) 274-8787, extension 115; or visit the CII Web site at www.childrensinstitute.org.)

What's New in Research

Childhood abuse affects adolescent functioning

Researchers examined the psychological and behavioral functioning of 322 psychiatrically hospitalized adolescents who reported histories of childhood abuse and found a significant difference in their behavior compared to those with no such history.

Subjects were given a battery of psychometric tests, including the Millon Adolescent Clinical Inventory. Childhood abuse scores of 30 or less or 70 or greater were used to create two study groups: adolescents with no abuse (93) and those with a high incidence of abuse (70). They were then compared demographically and on the battery of instruments.

The results were that the two groups differed substantially on most measures of psychological disturbance. When age and depression level were controlled, the high-abuse group was significantly more likely to have higher levels of dependency, suicidality, violence, impulsivity, substance abuse problems, and borderline personality tendency.

"In our group of psychiatrically hospitalized adolescents, patients who report childhood abuse are characterized by a complex array of severe psychological, personality, and behavioral problems that distinguish them from those patients who do not report childhood abuse," the investigators conclude.

Grilo CM, Sanislow C, Fehon DC, et al.: Psychological and behavioral functioning in adolescent psychiatric inpatients who report histories of childhood abuse. *American Journal of Psychiatry* 1999; 156:538-543. For reprints, contact Carlos M. Grilo, Ph.D., Yale Psychiatric Institute, 184 Liberty St., New Haven, CT 06519.

Meds have small effect on breastfeeding babies

A study of 35 nursing infants whose mothers were receiving antidepressants or benzodiazepines for psychiatric conditions determined that the drugs have minimal effect on the infants, but monitoring toxicity levels is recommended.

The women in the study had taken the medications during pregnancy and during breastfeeding. Blood samples were obtained from the infants, both during their gestation and postpartum. When there was a detectable concentration of medication found, information about the infant's behavior was obtained through a report from the mother.

Twenty six, or 74 percent, of infants had serum medication concentrations below the laboratory limit of detection. In the remaining 26 percent of the infants, serum concentrations of psychotropic medications and/or active metabolites for the drugs were detected. In each of those cases, though, infants had been exposed to the medication during pregnancy. However, medications were not detected in infant serum when the mothers had taken the agents only during the postpartum period. There were "no readily apparent difficulties" with the infants reported by the mothers, the authors note.

"These data support the low incidence of infant toxicity and adverse effects associated with antidepressant and benzodiazepine use during breastfeeding," the researchers conclude. Given the limited accumulated data regarding serum concentrations of psychotropic medications in breastfeeding infants, no single agent seems to be safer than another. Therefore, choice of pharmacologic treatment should be guided by the likelihood that it will result in restoration of maternal psychiatric well-being."

Birnbaum CS, Cohen LS, Bailey JW, et al.: Serum concentrations of antidepressants and benzodiazepines in nursing infants: a case series. *Pediatrics* 1999; 104:11-22. For reprints, contact Lee S. Cohen, M.D., Perinatal Psychiatry Clinical Research Program, Massachusetts General Hospital, 15 Parkman St., WACC 812, Boston, MA 02114; e-mail: lcohen2@partners.org.

Adolescents with MDD have high rate of suicide

Researchers conducted a prospective, case-control study of 73 adolescents who had major depressive disorder (MDD) and 37 control patients with no evidence of past or current psychiatric disorder and found a higher rate of suicide for those with MDD when they reached adulthood. Assessments were conducted from 1977 until 1985, with follow-up 10 to 15 years after initial assessment by an independent team with no knowledge of the initial diagnoses.

The main outcome measures of the study were suicide, suicide attempts, psychiatric diagnoses, treatment utilization, and social functioning.

The clinical outcomes of adolescent-onset MDD into adulthood compared with control subjects without psychiatric illness included a high rate of suicide (7.7 percent), a five-fold increase for first suicide attempt, and a two-fold increased risk for MDD. There also was an increased occurrence of psychiatric and medical hospitalization and impaired functioning at work, social situations, and in family life. Thirty-seven percent of patients who had been diagnosed with MDD during adolescence survived without having an episode of MDD during adulthood.

"There is substantial continuity, specificity, morbidity, and potential mortality from suicide into adulthood in adolescent-onset MDD patients," the investigators conclude.

Weissman MM, Wolk S, Goldstein RB, et al.: Depressed adolescents grown up. *JAMA* 1999; 281:1707-1713. For reprints, contact Myrna M. Weissman, Ph.D., College of Physicians and Surgeons of Columbia University, New York State Psychiatric Institute, 1051 Riverside Dr., Unit 24, New York, NY 10032; e-mail: weissman@child.cpms.columbia.edu.

Resources

AAP publishes child-care books for parents

The American Academy of Pediatrics (AAP) has three child care books available to parents. Advice on child-rearing is provided by leading pediatricians from birth to adolescence, covering everything from preparing for childbirth to nurturing a child's self-esteem to understanding adolescent sexuality. The three books are: *Caring for Your Baby and Young Child: Birth to Age 5*; *Caring for Your School-Age Child: Ages 5-12*; and *Caring for Your Adolescent: Ages 12-21*.

Hardcover copies of the book are $19.95 each; softcover editions are $14.95 each. A three-volume hardcover set is available at a discount for $49.95.

For more information, contact the AAP, Publications Department, P.O. Box 747, Elk Grove Village, IL, 60009; phone: (800) 433-9016; Web site: www.aap.org.

Substance abuse resources available on teens

The federal Center for Substance Abuse Treatment (CSAT) recently released two new treatment improvement protocols (TIPS) on adolescent substance abuse. One TIP addresses the issue of screening and assessment and the other describes the best practices for treating youth with substance abuse problems.

TIP #31, Screening and Assessing Adolescents for Substance Abuse Disorders, defines the warning signs for substance abuse disorders in teens and when to screen adolescents for substance abuse and seek assessment of the problem. TIP #32, Treatment of Adolescents with Substance Abuse Disorders, describes the differences between treating adults and adolescents and discusses treatment options geared to teens.

The TIPS may be accessed at the CSAT's Web site at www.samhsa.gov; or contact the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686.

Good books help children understand the problems of aging

As people age, they often change in ways that can be confusing and upsetting to children. One way to make them more comfortable with aging relatives or friends is to read them stories about children in similar situations. The following books can help children understand and cope when older loved ones become physically or mentally disabled.

A Window of Time *by Audrey O. Leighton, illustrated by Rhonda Kyrias. Nadja Publishers, 1995. (ISBN 0-9636335-1-1)*

This is the story of Jack and his grandpa's "time machine that takes him back to when he was young." Everyone in his family knows that Grandpa slips back and forth between present reality and his childhood memories and everyone enjoys him either way. The illustrations are appealing (flying clocks and cows) and beautifully rendered. The total acceptance of Grandpa as he is right now is worth emulating.

Wilfrid Gordon McDonald Partridge *by Mem Fox, illustrated by Julie Vivas. Kane/Miller Book Publishers, 1989. (ISBN 0-916291-26-X)*

Wilfrid Gordon lives next door to "an old people's home" and knows all the residents. His favorite is Nancy Alison Delacourt Cooper because, like him, she has four names. When he overhears his parents saying Miss Nancy has lost her memory, he asks the other residents, "What's a memory?" From their answers, he puts together a box of favorite things, which he presents to Miss Nancy. As each item stirs a story in her, they smile to discover those found memories. A great introduction to reminiscence, the illustrations are pure delight.

The Memory Box *by Mary Bahr, illustrated by David Cunningham. Albert Whitman & Company, 1995. (ISBN 0-8075-5053-1)*

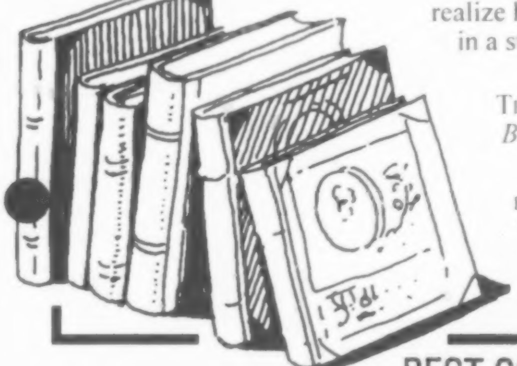
Zach visits his Gram and Gramps in the north woods each summer. This year Gramps suggests they start a Memory Box for special family tales and traditions, pictures and souvenirs. A young person and old person must fill the box together and store it in a place of honor so the memories are saved forever. When Gramps gets lost one day near his home in the woods he knows well, Zach realizes the importance of savoring their special moments. Though superficially similar to *Wilfrid Gordon McDonald Partridge*, this book works well with an older child, in that Alzheimer's disease is named and lightly explained.

Fireflies, Peach Pies and Lullabies *by Virginia Kroll, illustrated by Nancy Cote. Simon & Schuster (Juvenile), 1995. (ISBN 0-689-80291-9)*

This story of a death and funeral of someone with memory loss may not be a favorite for rereading but it has a worthy message. Francie loves her Great-Granny Annabel and is upset when her mother describes her as an empty shell who will be remembered for her losses. When Granny dies, Francie goes around the funeral home having each person write a brief memory of her. It's a good lesson in always looking for the "whole person."

Sachiko Means Happiness *by Kimiko Sakai, illustrated by Tomie Arai, with Japanese characters. Childrens Book Press, 1990. (ISBN 0-89239-065-4)*

Sachiko, who is quite resentful of her grandmother at the outset, comes to realize how frightened she is and how terrible it must be to always feel you are in a strange place.



Thundercake *written and illustrated by Patricia Polacco. Philomel Books, 1990. (ISBN 0-399-22231-6)*

Thundercake is the story of a young girl whose Russian grandmother helps her overcome her fear of storms while they bake a "thundercake" together. The recipe (with surprising ingredient of pureed tomatoes) is in the back of the book, so this would make a neat intergenerational activity, too.

(Continued, over ...)

CHICKEN SUNDAY *written and illustrated by Patricia Polacco. Paper Star, 1998. (ISBN 0-698-11615-1)*

This book is about a young white girl who lives in an integrated neighborhood where her two best friends are African-American brothers. She adopts their grandmother as hers and the three friends especially enjoy having chicken dinner after Sunday church services. Conflict comes when the three friends are falsely accused of throwing raw eggs at the back door of an old man's shop, but all ends well. This is ultimately a tender story about the goodness of people.

FOX SONG *by Joseph Bruchac, illustrated by Paul Morin. Paper Star, 1997. (ISBN 0-698-11561-9)*

A poetic book about Native American grandparents and grandchildren, *Fox Song* is about a young girl's memories of her grandmother — making baskets from the barks of trees, gathering the sap for maple syrup — who has recently died. Meant for grade school children, it has a deeper, more complex story line than many of these books, but like the others, is a tender tale, beautifully illustrated.

LOOP THE LOOP *by Barbara Dugan, illustrated by James Stevenson. Puffin Books, 1993. (ISBN 0-14-054904-8)*

This is the story of the friendship between Anne, a child of about five or six, and Mrs. Simpson, a feisty, wheelchair-bound, yo-yo playing elderly widow. Although Mrs. Simpson's health deteriorates as the book progresses, the story is warm and funny. Without being preachy, it manages to convey both the frailty of Mrs. Simpson and her triumphs. At one point she says, "I'm magnificent, and I know it." By story's end, we all know it.

THE BEDSPREAD *by Sylvia Fair. William Morrow & Company, 1982. (ISBN 0-688-00877-1)*

This is a marvelous illustration of how two people can have the same experience, see it differently, and both be right. It speaks clearly to individualizing care and to the fact that there is more than one right answer to most problems. Amelia and Maud are two elderly, bed-bound sisters who sleep at opposite ends of a very long bed and share a white bedspread that they both agree is boring. Dividing the bedspread in half, each embroiders their childhood home as she remembers it. Maud is a meticulous, careful perfectionist who expertly works in every stitch she knows and painstakingly cuts and sews 326 calico bricks. Amelia is a sloppy, careless embroiderer, but a joyful colorist who remembers blooming flower boxes, creeper vines and peacocks on the roof. In the end, each appreciates the other's memories.

Source: Adapted with permission from *Wiser Now*, Better Directions, Inc. Vol. 8, Issue 3; March 1999. Kathy Laurenhue, editor; (800) 999-0795.

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Recommended Reading

THE NATURE OF SCHOOL BULLYING: *A cross-national perspective — P.K. Smith, Y. Morita, J. Junger-Tas, D. Olweus, R. Catalano, & P. Slees (Eds.) NY: Routledge, 1999, $100. (hard), $39.99 (soft), 384 pages. To order, call (800) 634-7064.*

THE DEVELOPMENT OF EMOTIONAL COMPETENCE — *Carolyn Saarni. NY: Guilford Press, 1999, $41.95 (hard), $21.95 (soft), 381 pages. To order, call (800) 365-7006.*

THE COMPANY THEY KEEP: FRIENDSHIP IN CHILDHOOD AND ADOLESCENCE — *Bukowski, Newcomb and Hartup. NY: Cambridge University Press, 1998, $64.95 (hard), $24.95 (soft), 426 pages. To order, call (800) 872-7423.*

Family mealtimes encouraged

The "Family Mealtime Initiative," a new fact sheet, is available on the Internet from the Greater New Milford (Conn.) Area Healthy Community 2000 Task Force on Teen and Adolescent Issues. The initiative was begun by the Rev. Michael J. Moran, a member of the task force and senior pastor of the New Milford First Congregational Church. Moran spotted an article about keeping teenagers out of trouble and found that the most effective solution was the family meal. Even though it is difficult to find time for families to eat together, making it a high priority helps fight teen problems, Moran and other task force members believe.

Facts determined by the task force include:

- The number of days that adolescents eat meals with their families is one of the most powerful predictors of whether or not they were "adjusted" — meaning they didn't take drugs and had better peer relationships.
- A positive relationship was found between elementary school students' academic success and at-home meals with their families.
- Family mealtimes are important for helping children develop appropriate socialization skills.

To access the family meal initiative, visit the Web site at www.familymealtime.org; or contact, Family Mealtime, P.O. Box 2082, New Milford, CT 06776.

Anti-violence project launched by MTV,

Music Television (MTV) and the American Psychological Association (APA) have produced a guide to help teens identify the warning signs of violence and respond appropriately. The guide was produced as part of a 30-minute program on an MTV special broadcast earlier this year. Like the program, it deals with how to recognize the early signs of violence and how to "fight for your rights" and "take a stand against violence."

The guide is available free of charge by calling (800) 268-0078 or by accessing the APA's Web site at www.apa.org.

The Illinois Psychological Association (IPA) in Chicago also offers programs led by psychologists to school and community groups about the warning signs of teen violence. For more information about the IPA programs, contact Nancy Molitor, Ph.D., at (847) 570-1663 or Katherine Klehr, Ph.D., at (847) 446-4800.

Core attitudes

from page 1

1. The ***Excitement*** subscale measures perceptions of guns as intrinsically exciting, stimulating and fun (e.g., "I bet it would feel real cool to walk down the street with a gun in my pocket.").
2. The ***Power/Safety*** factor assesses the belief that guns and violence bring feelings of power and safety to the people who use them (e.g., "Kids in gangs feel safe because they've got people to back them up.").
3. ***Comfort*** with aggression involves a comfortable acceptance of violence in the youth's world (e.g., disagreement with the item, "The people I respect would never go around with a gun because they're against hurting people.).
4. ***Aggressive Response to Shame***, the largest factor, is also the most complex: These items involve a two-part dynamic consisting, first, of hypersensitivity to disrespect from others and, second, the belief that assaulting an insulting individual effectively undoes feelings of shame and damage to self-esteem (e.g., "If somebody insults you, and you don't want to be a chump, then you have to fight.").

There is substantial evidence for the AGVQ's validity. Scores predict handgun ownership by young

81

people, with low scores associated with a 1/125 chance and high scores with a 1/3 chance of gun ownership. AGVQ scores also correlate with a variety of measures of behavioral aggression, anger and hostility, interpersonal problems and psychosocial skills.

Most exciting interventions for the prevention or treatment of aggression are based on psychosocial skill training, with little or no attention to violence-related attitudes or motives. The assumption seems to be that aggressive youth generally want to be nonviolent but are unable to do so because they lack the skills necessary for nonviolent management of conflicts. However, clinical experience suggests that some youth are not motivated to learn nonviolent psychosocial skills, and results from the AGVQ help to explain why: Aggressive youth often find violence exciting, believe it provides power and safety, do not feel uncomfortable with its occurrence, and feel it is the only honorable response to disrespect. If this set of attitudes is present, it would be surprising if an individual were motivated to learn nonviolent conflict management skills. But if violence-prone attitudes could be changed, psychosocial skill training would proceed more effectively.

This reasoning suggests that interventions would be strengthened by components that change attitudes favorable to guns and violence. The User's Manual for the AGVQ (Shapiro, in press) includes detailed suggestions for planning treatment that is individualized on the basis of assessment results. The core idea derives from the fact that the needs involved in the AGVQ factors are not, in and of themselves, either abnormal or problematic. All youth have needs for feelings of excitement, power, safety and pride. These needs become problematic only when youth see violence as the most effective way to meet them. Therefore, our interventions involve the following, three-part sequence:

1. Affirm the legitimacy of the youth's needs for excitement, power, safety, and pride.
2. Question the effectiveness of violence as a way of meeting these needs.
3. Provide more effective, nonviolent strategies for achieving these goals.

The first two steps function as a motivational springboard for the third, which then develops into the psychosocial skill training comprising the bulk of the total intervention.

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Peacemakers program

This approach has been incorporated into several different intervention modalities. The Peacemakers Program is a school-based intervention involving a prevention component delivered by teachers and a remediation component delivered by counselors. There is training in anger management, problem-solving, assertiveness, communication, and conflict resolution as well as work on peer group processes and nondidactic procedures designed to infuse program material into the school culture.

Evaluation results have been extremely positive: Pre/post-intervention assessment, with comparison to a control group, found that Peacemakers resulted in a 41 percent decrease in aggression-related disciplinary incidents and a 67 percent reduction in suspensions for violent behavior.

The Coolien Challenge

The Coolien Challenge is a violence prevention tool in the form of a computerized learning activity on CD-ROM. This interactive multimedia experience is presented to young people as a computer game, but it provides serious work on violence-related attitudes and psychosocial skills. The program's use of video, audio, graphics and music, as well as the interactive and individualized nature of the activity, make it very appealing to youth. In addition, pilot-testing data indicated the game was particularly attractive to youth having difficulties with aggression. State-of-the-art computerized multimedia technology provides exciting opportunities for development of creative interventions. ■

Jeremy P. Shapiro, Ph.D., is a clinical child psychologist specializing in youth violence research and prevention program development. He is also director of the Center for Research, Quality Improvement and Training of Applewood Center, Inc. He can be reached at 2525 East 22nd St., Cleveland, OH 44115; (216) 696-5800; fax (216) 696-6592.

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1. Shapiro, JP: Users manual for The Attitudes toward Guns and Violence Questionnaire. Los Angeles: Western Psychological Services. (In press)

2. Shapiro JP, Dorman RL, Burkey, et al.: Development and factor analysis f a measure of youth attitudes toward guns and violence. *Journal of Clinical Child Psychology* 1997; 26:311-320.

U.S. teens

from page 1

about 60 percent. The proportion of girls reporting condom use also increased, from about 40 percent in 1991 to about 50 percent in 1997.

Another positive trend showed up in the proportion of high school boys reporting multiple sex partners. The percentage of boys with four or more sexual partners dropped from more than 20 percent in 1991 to about 15 percent in 1997. Among high school girls, the ratio remained about the same.

Recent data from the National Survey of Family Growth yielded additional good news: An increase in the proportion of 15- to 19-year old girls who report using contraception the first time they had sexual intercourse. In 1982, less than half said they used a contraceptive their first time. By 1995, the proportion was more than 70 percent.

STDs remain high

Nevertheless, U.S. teens continue to suffer the highest age-specific rates for STDs of any population in this country, and the highest age-specific proportion of unintended pregnancy.

About three million new cases of STDs are diagnosed each year among people age 19 and younger, according to Santelli. And about four in 10 young women will experience a pregnancy.

"Clearly, we're not doing something quite right in this country," Dr. Santelli said.

Carol M. Cassell, Ph.D., M.P.H., director of a CDC demonstration project on community-based teen pregnancy prevention, a former vice president of Planned Parenthood of America, told conference attendees that a key step is to help parents do a better job of talking with their kids about birth control and sex.

According to a June 1996 Kaiser Family Foundation Survey on Teens and Sex, parents are more likely to talk with teenagers about AIDS than about birth control. The random national telephone survey of 1,510 teens found that while 69 percent of the kids had talked with their parents about AIDS, only 46 percent had a conversation about birth control.

When asked what's wrong with the way they get information about sex and birth control, teenagers' top complaint was that adults treat them as though they can't make their own decisions. More than two-thirds of the teens surveyed said adults provide the information when it's too late, and almost half said the information doesn't include enough detail about how to use birth control, or where to get it.

Asked which topics they personally need more information about, 22 percent of surveyed teens cited "how girls got pregnant." Even among sexually active teens, 24 percent felt they needed to know more about how pregnancy occurs.

In the Kaiser survey, 40 percent of teens said teachers and school were an important source of information about sex and birth control: 36 percent cited parents. Only 9 percent cited doctors and nurses. ■

For more information, contact Dr. John Santelli at The Centers for Disease Control and Prevention (Adolescent and School Health), Atlanta, GA, (770) 488-3212.

AAP report highlights troubling trends in teenage pregnancy

A policy statement and guidelines from the American Academy of Pediatrics (AAP) indicate that, although teen pregnancy rates are decreasing overall, the 1996 birth rate for babies born to teenagers was still higher than the rate for 1980, with more than one million U.S. teenagers becoming pregnant each year. The AAP also reports that birth rates are only mildly decreasing among Hispanic teens, very young teens, and teens having second pregnancies.

The AAP statement lists several troubling trends:

- The neonatal death rate is three times higher for babies born to adolescents.
- The risk of having a low-birth weight baby for teenagers is double the rate of adults.
- The United States has the highest adolescent birth rate of all developed countries.
- The birth rate to unmarried female teens has been rising steadily for the last 30 years. Birth rates for unmarried adults also have risen dramatically, so births to unmarried teens reflect a larger societal trend toward single parenthood.
- In most cases of adolescent pregnancy, the baby's father is older than 20 years of age.

The AAP is recommending that pediatricians and other providers encourage adolescents to postpone early sexual activity and promote abstinence, but also to ensure that all sexually active adolescents have knowledge of and access to contraception.

For more information, contact Gina Steiner, AAP, 441 Northwest Point Blvd., Oak Grove Village, IL 60007-1098; phone: (847) 981-7872.

Guest Commentary

Too much self-reflection yields too little insight

By Thomas J. Cottle, Ph.D.

Every human encounter, Rollo May asserted, opens the possibility for anxiety and joy. It allows the possibility of our being "opened up," not only to another person, but to ourselves. But opening up to another and to ourselves is risky, an exercise modern culture may not wish for us to attempt, and hence distractive forces get in the way of our creating authentic relationships with others, and ourselves.

An example of such a distraction is found in the concept of self esteem. If we listen to popular culture pundits we are led to believe that mental health is found in the capacity to love oneself, accept oneself and believe in oneself. While these are surely valuable human ingredients, they don't begin to touch the delicate and complex work of interactions with others and oneself. Self exploration, consciousness, identity and recognition — the cornerstones of self reflection — are made possible by maintaining and internalizing risky and joyous relationships, which are not at all synonymous with a simplistic conception of self esteem. In fact, May suggests that *agape*, concern for another's welfare, is more central to the exploration of self than esteem.

> *Of course we want people to feel good about themselves, but this notion is about as superficial as believing that a couple of bargain purchases will make one feel healthy.*

In a sense, self esteem is little more than eros turned inward. Of course we want people to feel good about themselves, but this notion is about as superficial as believing that a couple of bargain purchases will make one feel healthy. Esteem, in other words, is the distractive objective or construct, not the genuine one. Personal self exploration and the genuine recognition of self derived from it, often are felt as assaults on esteem. Some things I discover about myself and my world do not bring me joy. Adolescents know this well. Apparently, there are certain things better left not only unsaid, but unconscious. Still, the search for self leaves no stone unturned; sadness and joy lie just inside every cave.

At what point can it be said that a person has entered adolescence? (Keep in mind that, like infancy, childhood, middle age and old age, adolescence is little more than a theoretical construct.) Normally, the answer is that biology dictates the commencement of adolescence, but that is hardly sufficient.

Another approach may be that psychologists felt a need to construct something called adolescence because they recognized that young people were beginning to undertake a sort of mind work that was to be distinguished from the mind work of children.[1] The very contemplation of identity, one's calling, the reasons for being alive, common discussion topics in high school courses, was made possible by cognitive development, surely, but signaled that youngsters were beginning to find their way into self examination. We invariably ask children: What do you want to be when you grow up? Adolescents begin to ask themselves: Who am I, really? So another answer to what marks the onset of adolescence may be when people begin to descend into the world of what May called the Eigenwelt, the world of self thrown against itself.

We know, however, that this descent does not always generate happiness. Indeed, it is filled with risk if not dread. It may be scary in ways no movie has ever been for adolescents. Either way, it brings a tremor to adolescents to which they respond in a variety of forms. They may act out, even violently, or feel the fright, exhilaration, confusion, sadness or anxiety associated with risk taking. They may attempt to deny sensations that cause them to feel inauthentic, or suppress them altogether, in which case alcohol and drugs seem useful paraphernalia. After all, the message of the culture continues to be: When feeling uneasy, medicate yourself.

The agents of culture, namely schools and parents, seek to quiet the moods and cease the exploration of the inner caves by dragging adolescents out of their private contemplation into the sunlight of corporate America. When the going gets tough, youngsters learn early, the tough go shopping, or better yet, seek entertainment. So the double message to adolescents, not so incidentally a gold mine for industry, is pull yourself out of the caves of self reflection and just work to feel good about yourself. If we make self esteem the order of the day, and not self knowledge, we will find, lamentably, that in the end self accumulation, not self examination, rules.

Thomas J. Cottle is a sociologist, clinical psychologist and professor of education at Boston University. His books include *Children's Secrets*; *Barred from School*; *Time's Children*; and the forthcoming, *At Peril: Stories of Injustice*.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Special Back-to-School Issue

National effort to stem cheating epidemic begins this month

By Donald L. McCabe, Ph.D., Rutgers University, and Edward F. Tate III, Educational Testing Service

Although students almost certainly have been cheating since the beginning of time, recent research indicates that the number of students who cheat has reached almost epidemic proportions.

A focus group conducted last spring with high school students suggests that the student who doesn't cheat today is the exception. Surveys of college students suggest they cheat more often and in more egregious ways than previous generations. Add to this the many new possibilities for cheating introduced by the Internet and there seems to be genuine cause for concern.

> ***Although tests and exams on most campuses with traditional honor codes are unproctored, surveys show that the level of cheating on these campuses is significantly lower than it is on campuses that proctor their exams.***

Despite this somewhat gloomy picture, we are convinced that there is cause for optimism.

A growing number of elementary and secondary schools are introducing character education programs (see *CABL*, January 1999) and there seems to be increasing activism among college students to address the issue of academic honesty in more effective ways. This month, in a major public service advertising program, the Advertising Council and the Educational Test-

(turn to 5)

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Vol. 15, No. 9 September 1999

Inside This Issue

Behavioral intervention in elementary school yields long-term positive effects. *See page 3*

Compared across cultures, child behavior checklists aid assessment process. *See page 4*

Intrauterine exposure to crack results in decreased growth. *See page 4*

Nursing infants of mothers who smoke have significantly higher levels of nicotine byproduct in urine. *See page 5*

Guest Commentary: What does the medicalization of ADHD say about the practice of mental health in the United States? *See page 8*

This month's client handout:
School rankings: sound and fury that can hurt kids

Discipline in Schools

School-based disciplinary measures affect behavior outside of school

By Ennio Cipani, Ph.D.

A high school basketball coach in Richmond, Calif., made recent national news by locking his entire squad of players out of practice and canceling all scheduled games. He did this because several student athletes were not meeting a contractual obligation to maintain standards of attendance and academic performance in school. The inability of some players to live up to their agreements affected the entire squad.

Several weeks later, a strategy of punishing young people who misbehave outside of school through disciplinary measures in school — expulsion, for instance — was adopted in a New York school district.

Putting aside for the moment the issue of whether or not these strategies are appropriate, a more salient question would be: Do these kinds of strategies work? Are the young people whose behavior causes an entire group of peers to lose something of value, or find themselves expelled for misbehavior, less likely to repeat the offense?

The answer is: yes, sometimes.

(turn to 7)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

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Keep Your Eye On

... foster families.

A study from the Ohio State University in Columbus found that foster parents are more likely to continue that role if they feel they receive support and encouragement from the agency social workers with whom they work.

The study involved a survey of 539 active foster parents. The four greatest predictors of satisfaction involved the relationship between the foster parents and the social services agency through which they fostered children. For example, there were higher levels of satisfaction when social workers showed approval for the foster parent doing well and provided support. Predictors of low satisfaction included not feeling competent to deal with psychological or behavior issues related to the foster child and dealing alone with agency rules and regulations.

Nolan Rindfleisch, Ph.D., co-director of the study and emeritus faculty in social work at the Ohio State University recommends that social agencies implement "sound support plans" to improve relationships between foster parents and social workers.

For more information, contact Nolan Rindfleisch, Ph.D., The Ohio State University, 1125 Kinnear Road, Columbus, OH 43212; phone: (614) 436-7458; e-mail: Rindfleisch.1@osu.edu.

... the accuracy of hearsay.

Adults may have difficulty accurately remembering recent conversations they had with children, indicating that hearsay testimony from children may not be factual. In a study of conversations between 224 mothers and their three- to five-year-old children, psychologists Maggie Bruck, Ph.D., and Stephen J. Ceci, Ph.D., found that mothers could accurately remember the basic gist of conversations they had approximately three days earlier, but could not accurately recall the structure of the conversations or important details that could be critical in courtroom situations.

"For hearsay testimony to be reliable, the adult must not only recall the gist of the conversation, but how the child's statements were elicited," says Bruck. "If information is derived from a child with an open-ended question, the answer is much more reliable than information derived from repeated or leading questions."

From the *American Psychological Association*, Washington, D.C. Drs. Bruck and Ceci are winners of the William James Award of APA's Division I (General Psychiatry) for their book *Jeopardy in the Courtroom*. For more information, contact Maggie Bruck, Ph.D., 410-614-1231; e-mail: bruck@hebb.psych.mcgill.ca.

... marijuana and driving.

An Austrian study indicates that both perceptual motor speed and accuracy were impaired in research subjects immediately after they smoked a cigarette containing 290 mcg/kg body weight of tetrahydrocannabinol (THC), or the active ingredient of marijuana. Subjects also had impaired cognitive function and difficulty concentrating. Although they were not evaluated while driving, the researchers note that those variables are "very important parameters of driving ability," and that driving impairment under the influence of marijuana should be further explored.

From the *Journal of Clinical Psychiatry*, June 1999. For more information, contact Ilse Kurzthaler, M.D., Department of Biological Psychiatry, Innsbruck University Clinics, Anichstrasse 35, A-6020, Innsbruck, Austria

... girls and obesity.

A school-based program aimed at teaching better dietary habits and reducing television viewing in adolescents was found to be effective only in girls, not boys, according to the American Medical Association. Steven L. Gortmaker, Ph.D., from the Harvard School of Public Health in Boston, and colleagues evaluated the impact of a school-based health behavior intervention known as "Planet Health" on the prevalence of obesity among boys and girls in sixth through eighth grades. "Developmental differences among boys and girls this age may have ... influenced these results," says Gortmaker, suggesting that girls may actually be more motivated to lose weight than boys.

From the American Medical Association. For more information, contact Brian Pace, 515 North State St., Chicago, IL 60610. Telephone: (312) 464-4311.

Reducing Violence

Interventions in elementary school have lasting effect

Interventions aimed at children throughout the elementary school years had long-lasting effects in reducing violent behavior, heavy drinking and sexual intercourse and in improving school performance at age 18.

This conclusion comes from a 12-year study of nearly 600 multiethnic children who began their education in 18 elementary schools in Seattle neighborhoods. The study, which examined programs involving teacher and parent training, was conducted by University of Washington researchers and appeared in the March issue of the American Medical Association's *Archives of Pediatrics and Adolescent Medicine*.

"The remarkable thing about this study is the breadth of outcomes, and that this intervention package has lasting impact through age 18," said David Hawkins, a University of Washington social-work professor and lead author of the study. "We now have clear evidence that helping teachers to teach better and parents to parent better pays off in a broad range of outcomes beyond the classroom."

The study showed that, at age 18, children who received the intervention in elementary school were 19 percent less likely to commit violent acts; 39 percent less likely to indulge in heavy drinking; 13 percent less likely to engage in sex; 19 percent less likely to have had multiple sex partners; and 35 percent less likely to have caused a pregnancy or become pregnant. In addition, children who received the intervention recorded higher overall grade point averages.

The intervention program starts when children enter grade one and continues through the sixth grade. Teachers receive five days of special training each year to learn such skills as interactive teaching, classroom monitoring, cooperative learning and proactive disciplinary skills.

Parents are taught positive reinforcement, how to monitor their children, and how to reduce their children's risk of early alcohol and drug use. Children are taught impulse control, how to get what they want without being aggressive, and how to recognize other people's feelings.

Children in the study were assigned to three groups. One group received the intervention program throughout elementary school, a second received an abbreviated version of the program in the fifth and sixth grades only, and the third received no intervention.

The behavior and school performance of the students who received the full intervention was significantly better than those of the control group, while students who received the abbreviated intervention differed little from those in the control group.

The intervention program was not successful in altering all negative behaviors, however. For example, the intervention did not have a major effect on reducing the proportion of students who had tried cigarettes or drugs at age 18, researchers said. ■

For more information about the study, contact David Hawkins at (206) 543-7655 or via e-mail at jdh@u.washington.edu.

Subscriber Services

For more information about a story in the newsletter, or to send press releases, contact Linda Watts Jackim, Senior Managing Editor, *The Brown University Child and Adolescent Behavior Letter*, 208 Governor Street, Providence, RI 02906; phone (401) 831-6020; fax (401) 861-6370.

What's New in Research

Child behavior checklists compared across cultures

Empirically-based assessment in terms of Child Behavior Checklist Syndromes permits comparisons of problems for children from diverse cultures, according to recent research.

Investigators compared Child Behavior Checklists for 13,697 children and adolescents, ages six through 17 years old, from general population samples in Australia, Belgium, China, Germany, Greece, Israel, Jamaica, the Netherlands, Puerto Rico, Sweden, Thailand, and the United States.

Puerto Rican youths had the highest scores, and Swedish youths had the lowest scores on almost all syndromes. Girls scored higher than boys on somatic complaints and anxiety/depression, but lower on attention problems, delinquent behavior, and aggressive behavior. There were "relatively small" differences found among most of the 12 cultures in total problem scores.

"In the assessment of an individual child, it is, of course, most helpful for clinicians to have appropriate norms with which to compare the child's syndrome and total problem scores," they conclude. "However, to help children from diverse backgrounds for which specific norms may not exist, clinicians need to integrate knowledge of the range of cross-cultural variations on particular syndromes with their appraisal of individual child and family characteristics when judging needs for interventions."

[For another view of checklists, see next month's issue.]

Crijnen AAM, Achenbach TM, Verhulst FC: Problems reported by parents of children in multiple cultures: the child behavior checklist syndrome constructs. *American Journal of Psychiatry* 1999; 156:569-574. For reprints, contact Alfons A.M. Crijnen, M.D., Department of Child and Adolescent Psychiatry, Sophia Children's Hospital, Dr. Molewaterplein 60, 3015 GJ Rotterdam, the Netherlands.

Infants' exposure to crack affects intrauterine growth

Exposure to cocaine/crack during early pregnancy decreases the intrauterine growth of exposed offspring in women with and without prenatal care (PC). This is the implication of research that looked at the effects of prenatal cocaine exposure on neonatal growth in one sample of women had who received PC and a sample who did not (NPC).

The women in the PC sample (295) were interviewed at the end of each trimester about their use of cocaine, crack, alcohol, tobacco, marijuana and other drugs. The women in the NPC group (98) were interviewed at delivery about their drug use during each trimester of pregnancy. In both samples, information also was obtained about sociodemographic, lifestyle, psychologic, and social support characteristics. Infants were examined postpartum by project nurses who were blind to maternal substance abuse status.

In both samples, cocaine/crack use during early pregnancy predicted gestational age, birth weight, length, and head circumference after controlling for the significant co-variates of cocaine use. The offspring of the NPC/cocaine group were significantly smaller than those of the PC/no cocaine group. However, the offspring of the PC/cocaine and NPC/cocaine groups did not differ.

These samples are being followed throughout childhood to determine whether there are long-term effects of pregnant cocaine/crack exposure on growth.

Richardson GA, Hamel SC, Goldschmidt L, et al.: Growth of infants prenatally exposed to cocaine/crack: comparison of a prenatal care and a no prenatal care sample. *Pediatrics* 1999; 104:18-35. For reprints, contact Gale A. Richardson, Ph.D., Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213.

Resource

Musical programs aimed at improving speech, sensory integration

Belle Curve Records in Boulder, Colo., has a variety of cassette tapes, compact discs, and booklets to provide information on raising children with sensory-motor, developmental, and social-emotional challenges. Through the use of therapeutic "Songames" and thematic play activities, the products are meant to be used by teachers, professionals or parents. The products were developed by professional therapists.

Available products include the following:

- "Songames for Sensory Integration," an audiotape and booklet that includes musical activities for improving fine and gross motor skills, muscle strength, and rhythmicity in children ages three to eight years old.
- "Marvelous Mouth Music" is 21-activity audiotape and booklet designed for children ages two to nine that helps with speech development through musical play.
- "The Alert Program" is an audiotape that features 15 songs and that uses the analogy of an automobile engine to introduce the concept of self-regulation to students.

For more information, contact Belle Curve Records, P.O. Box 18387, Boulder, CO 80308. Telephone: (888) 357-5867. E-mail: www.bellecurve.com.

School rankings: sound and fury that can hurt children

by Peter D. Relic

My youngest child, the blond, was labeled early on. He was labeled "gifted and talented" and benefited from strong, challenging academic programs in the schools he attended. He developed such a firm foundation and quiet confidence that he dared to launch a freelance writing career immediately after college. He is very successful.

My oldest child, the brunette, was a good student, but the word "outstanding" never featured prominently in her teachers' comments. She chugged through school and into college until, unexpectedly, campus politics lit a fire in her that blazes brightly to this day. Her college provided the spark, the arena and the support for her development as a leader. She was elected to offices no female student had ever attained, went on to four excellent years as a staffer on Capitol Hill, and is a very successful lobbyist today.

My black-haired middle child was a special education student who needed extensive remedial work, particularly with his speech and muscular coordination. He finished high school with a very solid record, was track captain and a three-year letterman in soccer, and was fortunate to study at a university that recognized his need for untimed tests and provided the facilities to help him build his manual dexterity and strength. He graduated in five years and is a foreman in a manufacturing plant today. He is very successful, too.

So … which of my children is best? Which of their schools is better than the others? Their colleges? Would you rank my offspring 1-2-3 or 3-2-1? How about 2-1-3 or the other way around? What if we can only list two — which would you leave out? If I ranked their schools, would it help you, as a parent, choose the "best" school for your children with their individual interests, talents and needs? Would it inspire other schools to serve their students better?

Of course it wouldn't.

As a society, we seem to have developed an addiction to ranking and ratings — and they have their place. I want *Consumer Reports* to tell me all about microwave ovens and kosher hot dogs and the relative merits of Saturns and Subarus.

But my sons and daughter are not commodities to be dealt with in such a way and neither are your children. Our children and schools will not be improved by being rated against one another. Earlier this year *Newsweek* magazine published a preposterous ranking of public schools, their roster of "The Top 100 High Schools" arrived at by dividing the number of Advanced Placement tests taken by the number of graduating seniors, but excluding those with selective admissions and smaller schools the magazine just couldn't get a handle on. *U.S. News & World Report* is planning to publish lists of "America's Outstanding Schools," not a ranking or rating, but indubitably a list of winners (those listed) and losers (those not listed). No good can come of this.

What we need to improve our schools is a grassroots commitment with mothers and fathers, grandparents and graduates, neighbors and friends all becoming involved with the schools, all giving of ourselves.

✓ **Give time:** Volunteer as a tutor, an envelope stuffer, a book shelver, or assistant coach. Say yes when you are asked to speak on career day — and think about doing it for another school

(Continued, over ...)

in addition to the one your child attends. Offer to do the demonstration in the laboratory or studio or theater. Create meaningful opportunities for student internships in your business. Accept the nomination to head the committee in the parent/teacher group, to run for the school board, or to serve on the school's board of trustees.

✓ **Give resources:** If you are in a position to buy a candy bar to support the junior class trip to Washington, D.C. or the state capitol, please do it. If you are inspired and able to endow a fund for music lessons for kids who can't afford them, for goodness sake, do it. When you have the opportunity to vote to support the bond issue to repair old schools or build new ones, you must do it — even if your children are in private schools or all grown up and living in another state where your grandchildren have good schools.

✓ **Whatever you give, give thoughtfully**: If each of us resolves to be a positive force for change we can improve our children's schools. Stigmatizing them with rankings and ratings, making them winners or losers, is all sound and fury, signifying nothing.

Peter Relic is president of the Washington, D.C.-based National Association of Independent Schools and a former superintendent of public schools.

The Brown University **Child and Adolescent Behavior Letter**

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Effects of tobacco smoke on nursing infants

Investigators studied newborns at risk for developing asthma and allergies based on a strong family history. They measured urinary cotinine (the byproduct of nicotine) levels in the infants as a measure of environmental tobacco smoke exposure. They also measured cotinine levels in the breast milk of breastfeeding mothers.

Of 507 infants, urinary cotinine levels during the first two weeks of life were significantly increased in infants whose mothers smoked. Breastfed infants had higher cotinine levels than non-breastfed infants, but it was only statistically significant if mothers smoked ($P<0.05$). Urinary cotinine levels were five times higher in breastfed infants whose mothers smoked than in those whose mothers smoked but did not breastfeed.

"Mothers should be encouraged to not smoke, and parents must be advised of the potential respiratory and systemic risks of environmental tobacco smoke exposure to their child, including the potential for future addiction to smoking," the researchers conclude.

Becker AB, Manfreda J, Ferguson AC, et al.: Breastfeeding and environmental tobacco smoke exposure. *Archives of Pediatrics and Adolescent Medicine* 1999; 153:689-691. For reprints, contact Allan B. Becker, M.D., Children's Hospital of Winnepeg, 820 Sherbrook St., Room AE101, Winnipeg, Manitoba, Canada R3A 1R9.

Honesty

from page 1

ing Service (ETS) will embark on a multi-year nationwide campaign to encourage students, teachers, and parents to address the reality of the widespread cheating that has developed in our educational systems.

Who cheats?

At an ETS-sponsored symposium held last January, panelists summarized some of the major findings of recent research on student cheating:

- Even though they may have cheated themselves, most young children understand cheating is wrong. However, by the time they become teenagers, many of these same children have learned to easily justify cheating behaviors.
- In a survey conducted by the Josephson Institute in 1998, 54 percent of the 9,585 middle school students surveyed admitted to one or more instances of test cheating.
- In a 1994 survey of 2,000 high-achieving students listed in Who's Who Among American High School Students, 80 percent said cheating is common in their schools and 78 percent admitted to having cheated themselves.
- In a 1993 survey of 1,793 students at nine selective state universities, 82 percent of the respondents admitted to one or more incidents of serious cheating and over one in four acknowledged repetitive test cheating.

The fundamental conclusion is unequivocal. Cheating is common in all levels of our educational system and is rationalized easily by many students.

What can be done?

Fortunately, some of the same research that has highlighted the magnitude of the problem also may point to some solutions. In particular, an ongoing study of cheating at 31 highly selective universities and colleges across the country suggests one successful approach is to give students direct responsibility for the issue of academic dishonesty.

In the absence of such strategies, it appears that a "we" vs. "they" mentality develops among students and almost anything "we" students can do to overcome the barriers that "they," the faculty and administration, place in our way can be justified.

One approach to co-opting students that has met with considerable success is traditional academic honor codes. Although tests and exams on most campuses with traditional honor codes are unproctored, surveys show that the level of cheating on these campuses is significantly lower than it is on campuses that proctor their exams. It appears students respond positively to the trust that is placed in them in honor code environments.

While honor codes are not a panacea, the success of most honor codes suggests students can, and will, respond to meaningful efforts to reduce serious cheating. The successful implementation of character education programs in many elementary and secondary schools is also cause for some optimism. Yet it is clear that students will not, and probably can not, take on this task alone.

A role for adults

One need only read the comments students make about cheating to realize that they feel the adults in their lives — parents, faculty, the larger society — have helped to create the problem and need to participate in some way to develop solutions.

Parents often place significant demands on their children to do well in school. This can be healthy, but not when it leads to parents doing a child's school projects or parents arguing with teachers and administrators any time their child does not receive an A, or when it leads to an over-emphasis on grades alone.

Faculty often do little to ensure that competition in their courses is fair — a major rationalization among students who cheat. Why should I work hard and get lower grades than someone who cheats when the teacher knows what's going on and does nothing about it? Why should I work hard when my teacher is so lazy — using old exams and assignments, showing little interest in students, and unwilling to help students who are having trouble?

Many students compare what they consider to be relatively harmless cheating to the serious behaviors that frequently occur in society and often go unpunished or lead to a slap on the wrist. Students hear almost daily about cheating and corruption in our political, legal and business systems that seem to have no real consequences. Many students have asked why they should be concerned about cheating in college when the message society sends is that cheating is often an acceptable way of achieving results.

Taking on cheating through the media

For the past few years, the media have been reporting about increased cheating in America's classrooms, raising awareness of this growing problem. This media attention was part of the rationale used by ETS when it proposed to the Ad Council in 1997 that the two nonprofit organizations collaborate on a public service advertising (PSA) campaign against classroom cheating.

Although the Ad Council responded enthusiastically, what quickly emerged was differing opinions on how students could best be persuaded not to cheat. Most troublesome was whether the campaign should focus on the negative aspects of cheating or on positive messages such as promoting learning for learning's sake. Griffin-Bacal, a New York City ad agency with a specialty in children's advertising, was recruited to help answer this question. They talked with many children about cheating in both focus groups and via the agency's nationwide Internet sampling system.

Their findings led the campaign team to focus on children ages 11 to 13 and an approach encouraging children collectively not to cheat. The strategy statement that emerged is relatively simple: "We want to be the best we can be — cool, fair and honest — kids who can be trusted."

Based on experience that sports is effective in grabbing the target audience's attention, the agency's creative staff produced several executions, most of which revolve around a friendly referee who embodies the conscience of young students. Final approval was given to two TV commercials based on the "ref in your head" theme and the tag line, "Cheating is a personal foul."

The campaign, incorporating radio and print advertising that shares the creative concepts in the TV spots, will be unveiled in September, just in time to benefit from the news media's "back-to-school" coverage. ETS and the Ad Council are building a grassroots network with organizations in education and public service to localize the campaign. The two nonprofit organizations also are attempting to recruit corporate sponsorship to help fund a wide range of "fulfillment" activities, such as producing printed materials and Web site content for children and adults whose interest is piqued by the public service announcements.

Additional funding also is being sought for a companion campaign aimed at parents, the need for which became clear during planning sessions for the kids' campaign.

What are the prospects for success?

The team developing the PSA campaign against cheating is getting a generally enthusiastic reception from the educators and others with whom they shared their plans. Teachers say it's important and welcome the help, particularly when it comes to enlisting parents in the effort to address the issue. Education leaders have been offering support, especially those involved with the growing character education movement, which seems to have tapped into public concern about our modern society, fueled by incidents

In a survey of more than 20,000 students, "Two-thirds of high school students do not talk daily with their parents. Half of them say they can bring home grades of C or lower and their parents won't be upset. One-third say that their parents 'don't have a clue' about what they are doing in school. Another third admit to spending the school day 'goofing off.'"

From "Beyond the Classroom: Why School Reform has Failed and What Parents Need to Do," by Laurence Steinberg, Ph.D., (Touchstone Books, 1997; 223 pages. ISBN: 0684835754).

such as the tragic shootings in Colorado's Columbine High School. And most journalists have shown considerable interest in the campaign, often it seems because they have wanted to write about cheating and need a new "peg" on which to hang a story.

Will the ETS-Ad Council campaign and the adoption of honor codes and character education programs actually help reduce the amount of cheating in American schools? Since there's never before been such a convergence of effort aimed at the problem, it's difficult to predict. The key may be encouraging all of the stakeholders — educators, parents, community leaders and students — to accept that cheating is an issue deserving our real and sustained attention. ■

Donald L. McCabe is professor of organization management with the Faculty of Management at Rutgers University, Newark, N.J. Edward F. Tate III is director of external communications at Educational Testing Service, Princeton, N.J.

Discipline

from page 1

In the case of one person's transgression resulting in discipline of everyone in a group, there is a body of applied research that supports this approach. In a number of classroom research studies, targeting the behavior of a few misbehaving students through group consequences did eventually change the behavior of the target students causing the problem. This procedure has been termed a group contingency.

When to use

Group contingencies are most effective when misbehavior is being fueled by peers. A common example is the class clown phenomenon — a child acts up to get attention, laughter and admiration from peers. In this case, punishing the group makes sense. Once the group suffers a consequence by losing a reward or privilege, due to the target student's antics, they will stop rewarding or encouraging the clowning behavior. However, if the child is clowning solely for the pleasure of aggravating a teacher, then a group contingency would not be effective, and the best way to handle this would be through individual consequences for the particular student.

For similar reasons, the use of expulsion from school to impact out-of-school behavior can fail. Expulsion can serve as an effective deterrent for young people who view this consequence as undesirable. But for those who do not want to be in school in the first place, expulsion might only serve as positive reinforcement for the undesired behavior. Some young people belong to peer groups that will positively reinforce behavior that leads to expulsion; they view "liberation" from school as an achievement to be lauded, rather than as something to be avoided.

Expulsion might work as a deterrent to others by inhibiting undesirable behaviors in other students who see that if they do "this," "that" will happen. But it may not work as a tool for changing some transgressors' behavior.

Clarity about the goals of discipline is the most important factor to consider when adopting disciplinary measures with young people. If modification of the individual transgressor's behavior is the outcome being sought, then the punishment must be a true deterrent. If making misbehaviors into a cautionary example for others is the goal, then the discipline policy need only affect the observers. Finally, group contingencies can work when the peer group acts as a reinforcer for the undesirable behavior. Sometimes it makes more sense to use individual consequences rather than a group contingency. Each situation is different, and requires different disciplinary actions. ■

Ennio Cipani, Ph.D., is a professor of child psychology and coordinator of a new doctoral program in school psychology at the California School of Professional Psychology, Fresno campus. He is the author of *A Functional Analysis of Behavior (FAB) Model for School Setting* (Cipani, 1999, Cipani & Associates) which covers seven possible behavioral functions and diagnostic categories for school problem behaviors. He is also the editor of a newsletter for teachers, school psychologists and administrators entitled *Positive School Practices* (Institute of Applied Behavior Analysis, Columbis, S.C.). He can be reached at (209) 456-2777 ext. 2242 or via e-mail at ecipani@cspp.edu.

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Guest Commentary

ADHD: Social problem versus medical disorder

By Louise Buonomano, Ed.D.

It is ironic that the diagnosis of attention deficit/hyperactivity disorder (ADHD) continues to increase at a time when, according to a 1998 federal report, children in America are healthier than in the past. This leaves us with a puzzling situation; namely why and how did attention and behavior problems come to be exclusively defined in the United States as a common childhood psychiatric disorder of organic origin?

While hardly recognized in the rest of the world, two million American children are diagnosed with ADHD, 1.3 million of whom take mind-altering drugs such as Ritalin. How can we employ a path that follows common sense and the laws of science and logic in evaluating the well-being of our children and this diagnosis?

The medicalization of ADHD raises some pressing questions about the theory and practice of mental health in the United States and the relationship between health and illness. Dr. Mark Vonnegut wrote in The Boston Globe, "The diagnosis of ADHD tells us more about ourselves than we want to know … [Parents] truly believe their child is suffering from an inability to learn or fit in, and without treatment will suffer peer rejection or academic failure." Vonnegut notes "that these children are diagnosed because they are in conflict with adults … ADHD offers an explanation that absolves parents and teachers of having any responsibility for the conflict." In most cases, the pressure comes from the school system that insists on a brain-disorder label.

Psychiatrists who design the scientific research, formulate the diagnostic categories and prescribe stimulant drugs, rarely explore how children are being viewed or taught. Most of the numerous educational and scientific journals tend to ignore such matters as classroom organization, teachers' attitudes toward the child, and all other complex components in the social system.

Moreover, by focusing on the symptoms and defining them as attention deficits, we ignore the possibility that the behavior is not a medical disorder, but an adaptation to a social situation. In effect, it diverts our attention from the family or school and from seriously entertaining the idea that the "problem" could be in the structure of the social system. Social problems become medicalized, and the targets of therapeutic activity are more likely than not to be the socially disadvantaged child.

Further muddying the waters is the fact that legislators have granted ADHD the status of disability, thus making low income parents of ADHD children eligible for Medicaid or Supplemental Security income benefits. Under Section 504 of the Federal Rehabilitation Act, schools have been forced to do all sorts of contortions to accommodate these children's medical and educational needs. As parents become more savvy about disability law and more aggressive about seeking services, tensions between families and schools are rising. As a result, legal and bureaucratic challenges are becoming more common. School officials are aware of how costly it can be to disagree with parents — in time, legal fees and community orientation. By implying a brain dysfunction etiology for cognitive and school-related problems, school officials are recommending neurological evaluations to establish eligibility for special education services. It is argued that the result is unnecessary medical expenses and unreasonable demands on already over-solicited pediatricians and pediatric neurologists.

The reason, says James Comer, a national educational expert and professor of child psychiatry and associate dean of Yale Medical School, can be put in one statement: "Schools are poorly equipped to deal with debilitating stresses suffered by many students." Much meaning must be drawn from this statement, but the conclusion is: "Teachers, principals and other educators can no longer operate as if social and personal stress had no effect on students' ability to learn." Comer contends that "there is a connection between good mental health, academic learning and successful performance in life. There is a connection between the feelings of children and the learning of children."

Presently, the medical and education professions should become more conscious of the social factors and the current controversial background of the ADHD movement. Only then can they serve, as no other disciplines can, to come to terms with the social factors so often ignored in evaluating the individual well being of our children. Only then can we creatively and humbly engage a path that follows common sense, reason and the laws of science and logic in further evaluating the ADHD diagnosis.

Louise Buonomano, Ed.D., is an assistant professor at the Henry Barnard School, Rhode Island College. She can be reached at (401) 739-0355; fax (401) 456-8128.

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BehavNews Digest

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Building Self-Esteem

Girls Choir of Harlem shepherds members through transitions

By Daniel Kertzner

On a warm summer's night two hundred enraptured people listened to seven elegantly dressed young ladies sing works by composers such as W.A. Mozart and Robert Schumann. The performance marked the completion of a week-long residency by seven members of the Girls Choir of Harlem at the Institute on the Arts and Civic Dialogue at Harvard University, and served to initiate a public discussion on the transition of girls from young women to adults in today's society.

> ***The success of the Girls Choir of Harlem is no secret, and it illuminates key criteria for assisting young girls making the difficult transition to adulthood.***

The Institute, founded and directed by the actress and playwright Anna Deavere Smith, examines how the arts can serve to launch public conversations on important social issues.

In the public discussion following the performance Carol Gilligan, who is the Patricia Albjerg Graham Professor of Gender Studies at the Harvard Graduate School of Education, said, "Democracy depends on the presence of people, on the presence of girls, coming into the public conversation."

Gilligan conducted several reflective sessions with the girls during the residency and was one of three practitioners from the field to participate in the discussion. She expressed concern that the experience of adolescent girls is going underground, saying, "Voice is a way of being present, not only

(turn to 6)

Vol. 15, No. 10 October 1999

Inside This Issue

Most self-inflicted firearm injuries related to guns of friends, relatives *See page 3*

To what extent does child abuse contribute to PTSD? *See page 3*

AAP offers guide on adolescent depression and suicide *See page 4*

Guest Commentary: Predicting and preventing violence *See page 8*

This month's client handout: **Helping kids cope with school violence**

Industrial Psychology

Knowing about parents' world of work promotes understanding in children

By Robert Perloff, Ph.D.

The field of industrial/organizational (I/O) psychology may seem remote from children. I/O psychologists and developmental psychologists, however, have much to offer each other. I/O psychologists could help explain to children what their parents do when they leave for work each morning, and why many parents seem to have little "quality time" left when they return from work.

An important lesson for children is that at home, the parents rule the roost, but at work the roost is usually ruled by others. From an organizational standpoint, the parent as worker experiences stress, joy, disappointment and numerous behavioral interactions involving the feelings of other people. Recently, family dynamics have changed rather dramatically. Formerly, in a two-parent family only the father went to work. Now, it is not unusual for both parents to work to increase family resources and seek occupational pleasure and personal fulfillment.

It is not a bad idea to provide

(turn to 5)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor of Anthropology (Research), Brown University

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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V.P. Marketing: Betty Rawls Lang

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Keep Your Eye On

... homeless children.

More than half of homeless school-age children have symptoms of depression, according to a new study from The Ohio State University in Columbus. Of 46 homeless children ages eight to 12, 57 percent had symptoms of depression, and 13 percent met criteria for clinical depression, according to Edna Menke, Ph.D., author of the study and an associate professor of community, parent-child, and psychiatric nursing at the university.

"Normally, we only expect 10 to 15 percent of children to have mental health problems," she says. "The homeless children in our study had a significantly increased risk of depression. These children live in extreme poverty and that may have detrimental effects on children's cognitive, emotional, physical and psychological health." (*Ohio State University*. For more information, contact Edna Menke at Ohio State University, College of Nursing, 1585 Neil Ave. Columbus, OH 53210. Telephone: (614) 292-8045. E-mail: Menke.3@osu.edu.)

... activity levels.

Overall, American children's activity levels still aren't up to par, according to a fitness expert. David Dzewaltowski, Ph.D., head of the department of kinesiology and the Kansas Health Foundation and distinguished professor of community health at Kansas State University, says, "Kids should accumulate about an hour's worth of activity every day. And for at least three days a week, kids should take part in activities of a vigorous nature for about 20 to 30 minutes."

Dzewaltowski recommends that parents turn off the TV and get outside and play with their children to increase their own fitness levels. Dzewaltowski says activity rates at the secondary school level also are too low, because schools often emphasize competitive sports, which limit participation to a select few children. (*Kansas State University*. For more information, contact David Dzewaltowski, Department of Kinesiology, 8 Natatorium, Kansas State University, Manhattan, KS 66506. Telephone: (785) 532-6765.)

... sterilization of disabled.

The American Academy of Pediatrics has extended recommendations regarding the sterilization of minors with developmental disabilities to include both males and females. The AAP encourages pediatricians to discuss the facts and implications of sexual maturation with people who have developmental disabilities as soon as puberty begins. The AAP says the focus should be on less radical options than sterilization whenever possible. [*American Academy of Pediatrics*. For more information, contact Joel Framer, M.D., F.A.A.P., A.A.P., 141 Northwest Point Blvd., Elk Grove Village, IL 60007. Telephone: (773) 880-8361.]

What's New in Research

Most guns in firearms injuries owned by family

"Most guns involved in self-inflicted and unintentional firearm injuries originate either from the victim's home or the home of a relative or friend," say the authors of new research.

Investigators in a retrospective case series in King County, Washington (Seattle) sought to determine the ownership and usual storage location of firearms used in unintentional and self-inflicted firearm deaths and injuries among youths from birth to 19 years old.

The identified youths sought medical treatment at a level I trauma center for a self-inflicted or unintentional firearm injury between 1990 and 1995 or presented to the county medical examiner with a fatal self-inflicted or unintentional firearm injury between 1990 and 1995.

Sources of data were county medical examiner records, regional police investigative reports, medical records from a level I trauma center, and surveys of victims' families.

There were 56 fatal injuries and 68 nonfatal firearm injuries; 59 were intentionally self-inflicted deaths and injuries, and 65 were unintentional deaths and injuries.

A firearm owned by a household member living with the victim was used in 65 percent (33) of 51 suicides and suicide attempts and 23 percent (11) of 47 unintentional injuries and deaths. In addition, a firearm owned by a relative, friend, or parent of a friend of the victim was used in 8 percent (4) of the 51 suicides and suicide attempts and 49 percent (23) of the 47 unintentional injuries and deaths.

Parental ownership of the gun accounted for 57 percent (20) of the 51 suicides and suicide attempts and 19 percent (9) of the 47 unintentional injuries and deaths. More than 75 percent of the guns used in suicide attempts and unintentional injuries were stored in the residence of the victim, a relative or a friend.

Grossman DC, Reay DT, Baker SA: Self-inflicted and unintentional firearm injuries among children and adolescents. *Archives of Pediatric and Adolescent Medicine* 1999; 153:875-878. For reprints, contact David Grossman, M.D., M.P.H., Harborview Injury Prevention and Research Center, 325 Ninth Ave., Box 359960, Seattle, WA 98104. E-mail: navajo@u.washington.edu.

Childhood trauma associated with adult PDs

According to research, childhood abuse and neglect may contribute to the onset of some personality disorders.

Researchers conducted a community-based longitudinal study to investigate whether childhood abuse and neglect increase the risk for personality disorders during early childhood. A representative community sample of 639 youths and their mothers in two counties in upstate New York received six psychosocial and psychiatric interviews from 1975 to 1993. Evidence of childhood physical abuse, sexual abuse, and neglect was obtained from state records and from self-reports in 1991 and 1993 when subjects were young adults. Personality disorders of the offspring were assessed in 1991 and 1993.

The study suggests that youth with documented childhood abuse or neglect were more than four times as likely as those who were not abused or neglected to be diagnosed with personality disorders during early adulthood after controlling for age, parental education, and parental psychiatric disorders. Childhood physical abuse, sexual abuse, and neglect were each associated with elevated personality disorder symptom levels during early adulthood after other types of childhood mistreatment were controlled statistically. Of the 12 categories of personality disorder symptoms from DSM-IV, 10 were associated with childhood abuse or neglect.

Johnson JG, Cohen P, Brown J, et al.: Childhood maltreatment increases risk for personality disorders during early adulthood. *Archives of General Psychiatry* 1999; 56:600-606. For reprints, contact Jeffrey G. Johnson, Ph.D., Box 60, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032.

Child abuse increases risk of PTSD

"Victims of child abuse [sexual and physical] and neglect are at increased risk for developing PTSD, but childhood victimization is not a sufficient condition," say researchers. "Family, individual and lifestyle variables also place individuals at risk and contribute to the symptoms of PTSD."

Investigators studied victims of substantiated child abuse and neglect that occurred from 1967 to 1971 in a midwestern metropolitan

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county area. The victims were matched on the basis of age, race, sex, and socioeconomic class with a group of non-abused and non-neglected children and followed prospectively into young adulthood. The study then sought to describe the extent to which childhood abuse and neglect increased the participants' risk for subsequent post-traumatic stress disorder (PTSD).

All subjects were given a two-hour interview that included the National Institute of Mental Health Diagnostic Interview Schedule to assess PTSD. The findings suggest that childhood victimization is associated with an increased risk for lifetime and current PTSD among abused participants, with 37.5 percent of childhood victims of sexual abuse (37.5 percent), 32.7 percent of those who were physically abused, and 30.6 percent of those who were neglected meeting DSM-III-R criteria for lifetime PTSD. However, the investigator notes that other factors appeared to play a role in PTSD risk as well, such as having a parent arrested, having a parent with drug problems, having a parent on welfare, or having a parent who was separated or divorced.

Widom CP: Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry* 1999; 156:1223-1229. For reprints, contact Cathy Spatz Widom, Ph.D., School of Criminal Justice, The University at Albany, 135 Western Ave., Albany, NY 12222.

Resources

'Baby Think it Over' offers real experience

A program designed to give teens a real taste of parenting a baby uses life-size, computerized dolls that require care on a regular basis. "Baby Think it Over" shows teens first-hand what having a baby means.

When a "Baby Think it Over" doll needs to be cared for, it will cry until a special care key, which is attached to the teen's wrist, is held in the baby. The teen must be with the baby for up to 30 minutes at a time. If the teen has properly cared for the infant, it will "coo" to signal the end of the care session.

The computerized box within the baby is sensitive to how the baby is held; if it is held upside down, for instance, it will cry.

The system is tamperproof, and it can be set so that the baby can be in a "cranky" mood, requiring more frequent care. The system ranks how well its user responds to the baby.

"Baby Think it Over" is designed to teach teens that caring for babies is not all cuddles and sweetness. The baby-dolls are available in Hispanic, African-American, Asian, American Indian, and Caucasian races and cost $250 each. For more information, contact Baby Think It Over, Inc., 2709 Mondovi Rd., Eau Claire, WI, 54701. Telephone: (800) 830-1416 or (715) 830-2040. E-mail: information@btio.com.

AAP offers guide on depression and suicide

The American Academy of Pediatrics is offering a guide "Surviving: Coping with Adolescent Depression and Suicide," that offers examples of teen suicide and how it can be prevented. The booklet discusses the leading cause of suicide — depression — and lists the warning signs of adolescent suicide. The guide is available on the AAP's Web site at www.aap.org/family/suicide.htm.

Miller beer prints "Let's Talk" about drinking

The Miller Brewing Company has published "Let's Talk," a free booklet that provides parents with basic information about beer, wine and other alcoholic beverages so they can have informed discussions with their children before they reach

Recommended Reading

Madness on the Couch: Blaming the Victim in the Heyday of Psychoanalysis — *Edward Dolnick. NY: Simon and Schuster, 1998; $25. (hardback), 3,698 pages. To order, call (800) 223-2348.*

Spoiling Childhood: How Well-Meaning Parents are Giving Children Too Much — But Not What They Need — *D. Ehrensaft. NY:Guilford Publications, 1997; $14.95 (softcover), 263 pages. To order, call (212) 431-9800.*

The Growth of the Mind: And the Endangered Origins of Intelligence — *S. Greenspan, with B.L. Benderly. Reading, MA: Perseus Books, 1997; $25. (hard), $16. (soft), 364 pages. To order, call (800) 386-5656.*

Helping kids cope with school violence

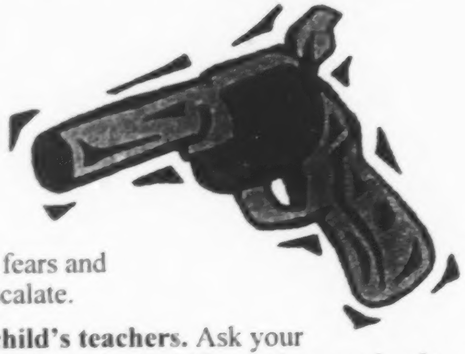
How will a child respond to a tragedy?

A child's response will depend on age, personality and maturity level. Some children, particularly those age nine and under, may be unable to grasp the reality of it, or comprehend that violence could affect their own lives. Others may be frightened that something could happen to them. And still others may attempt to protect themselves through denial, cynicism or apathy. Regardless of how your child responds, he or she will be looking to you for answers, guidance and support.

How can parents help?

Speak to your child about the incident, openly and honestly, adapting your conversations to the child's age. Children deserve honest answers, regardless of age. You do not have to provide every detail, but don't hold back too much information either; you should instill trust in your child while at the same time help him or her understand what happened. The following tips may be helpful:

- **Encourage your child to express his or her feelings.** Children usually feel better when they can talk about their feelings, ask specific questions such as "How do you feel? Does it make you feel scared? What worried you the most?" Encourage your child to be honest and open, and listen carefully for clues about hidden feelings or worries.
- **Reassure your child.** Respond to your child's feelings; acknowledge his or her fears; and continually reassure your child that he or she is safe. Stress that this was a rare incident, but avoid making false promises such as "Nothing like this will ever happen to you." Instead, offer your love, support and guidance and say things such as "I am here to protect you and to help keep you safe." In addition, remind your child that his or her teachers and the police are also looking out for his or her safety.
- **Monitor the media.** Monitor and limit the amount of television your child watches. If your child sees disturbing footage or interviews again and again, his or her fears and anxieties may escalate.



- **Speak to your child's teachers.** Ask your child's teachers and/or principal if any plans are in place to address the tragedy. Though school shootings are rare, after a tragic incident such as the one in Colorado, many schools speak to students about safety issues, and reassure them that they are doing everything possible to keep the children safe.
- **Pay close attention to your child.** Pay attention to your child's behavior. If you notice any unusual behavior changes, it may be a reaction to stress, fear or trauma. Learn how to recognize warning signs and seek professional help from a counselor, social worker, psychologist or other professional if necessary.

If your child expresses fear of going back to school, be sympathetic and talk to your child about his or her anxieties — but convince your child to be brave. Explain that it will take time for him or her to confront and gradually overcome anxieties — and reassure him or her that you will help. In addition, speak to your child's teacher about your child's anxieties, and ask him or her to provide additional guidance, support and encouragement. If your child's school phobia persists for an extended period of time, consult a professional for additional guidance and help.

What can parents do to help prevent violence?

Each time a violent incident occurs in our schools, parents want to know what they can do to protect their children. Though it will take a concentrated nationwide effort, the following tips may help:

- Alert your child to stay away from children who threaten violence and to report any threats or suspicious behaviors to school officials or to you.
- Keep the lines of communication open. Encourage your child to come to you with any concerns, problems or fears. In turn, ask your child questions about his or her friends, activities and feelings.

(Continued, over ...)

- Clear up misconceptions. Children frequently cite the media and their peers as their primary sources of information about violence, yet most cannot distinguish between dramatic images and actual dangers. For example, most children mistakenly believe that only strangers can be dangerous. Clear up any misconceptions and, rather than simply warning against strangers, teach your child how to detect uncomfortable situations or actions.
- Take a course in mediation skills so you can help your child or others peacefully work out problems and conflicts. Ask your school, police department, YMCA, or local hospital or counseling center if any courses are offered for adults and/or children.
- Be a good role model. Do not resort to violence for any reason and continually provide examples of nonviolent solutions to problems.
- Educate your child about guns and weapons and strictly forbid them from using them. Remind them that it is illegal and potentially deadly!
- If you have any guns in your house, they should be locked away and unloaded. Ammunition should be locked away separate from all guns. Additionally, all gun owners and their children should take a gun safety course.
- Work with schools and parent organizations to offer students self-control and stress-management courses.
- Help develop recreational and educational programs for young people in the community, so they will have opportunities for fun, constructive activities with adult mentors and supervisors.
- Work with educators, local government, law enforcement, and others in the community to solve problems involving crime, drugs, harassment and bullying.
- Help children get involved in volunteer activities. When children feel they are making an important contribution, they are less likely to turn to violence.
- Teach your child to express frustrations and anger in positive ways.

Finally, and most importantly, pay attention to warning signs and symptoms that may indicate that your child — or another — is troubled. Keep an eye out for at-risk behaviors such as skipping school, decline in grades, change in friends, temper tantrums, alcohol or drug use, carrying weapons, etc. These symptoms indicate that a child needs help and may have a tendency toward violence. Talk to the child and/or seek help immediately.

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The Brown University **Child and Adolescent Behavior Letter**

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drinking age.

The booklet offers suggestions for starting a conversation about alcohol use and abuse as well as different ways parents can set good examples for their children. Key messages are: Teach children to make responsible choices and, most importantly, *know* your children. For a free copy, call (800) 645-5376 or download a copy from www.thinkwhenyoudrink.com.

Video helps children deal with anger

Sunburst Communications in Pleasantville, N.Y., has a new video, "When I Get Mad," for guidance counselors and educators. It is meant to help urban kids in grades 2 to 4 get along better with friends, family and authority figures by demonstrating constructive ways to deal with the powerful emotion of anger.

The video and teacher's guide is available for $69.95. For more information, contact Sunburst Communications at (914) 747-4109. E-mail: www.SUNBURST.com.

Industrial Psychology

from page 1

one's children with this kind of work-and-life perspective to give them an understanding of how humans in our culture organize themselves for productivity and family earnings.

Part of employment is recruiting men and women to work for the company, and determining through assessment who will fit into the company culture with the skills and promise of growth to enable them to perform productively. The I/O psychologist is involved in this important function. The interpersonal and intellectual attributes needed to handle a particular job, the educational credentials, the kinds of past experiences are all assessed. Children must eventually learn about these considerations. They relate to the children's eventual adjustment, their motivations, their options, and other determinants of their developmental destinies.

The I/O psychologist must know how to set up training programs to teach people to perform certain tasks. How does one know whether a person has mastered the skills needed to fulfill the task? The I/O psychologist also must determine the level of the employee's performance and, accordingly, decide from this the employee's value to the organization, and thus his or her salary and other benefits.

The work of the psychologist is all about life in a culture that values and requires employment, and seeks to promote the best interests of all. These are lessons that every adaptable child must learn — or would do well to learn — by the time he or she is ready for employment. The entire process, if well learned, will help guard the child against workplace disappointments, e.g., failure to be promoted or to get an anticipated raise, or to have one's work recognized as valuable. Women with children are especially challenged by conflicts between work and their roles as mothers.

Disappointments invite diverse psychological problems, including depression, alcoholism, reliance on psychotropic or addictive drugs, and guilt. Crises, seldom masked from the employee's family, inevitably spill over from work to home.

Some I/O psychologists handle these problems through their skills as counselors, while clinical psychologists can provide remediation services including psychotherapy.

Sometimes ethical or ideological conflicts arise at work. An employee may know that a car has a mechanical flaw that might, under certain conditions, prove unsafe. To courageously confront the boss with this could cost the employee's job, whereas failure to report conflicts with the worker's conscience.

Sometimes people find themselves in bothersome working relationships, which can seem like minor annoyances to others, but to the persons affected can be of enormous importance. How well a child has learned to cope with diverse and annoying environmental and social circumstances earlier in life can influence patterns of behavior for the workplace during maturity. For example, there may be situations in a bank, where cheating or fraudulent behavior tempts the employee who has bills at home exceeding his or her income. Dismissal and legal proceedings may ensue. Again, childhood training and patterns of early-acquired patterns of conflict-resolution behavior are relevant.

I/O challenges with implications for child training

1. Leadership: What are the characteristics of a successful leader? Can leadership be taught or learned?
2. Managing: What essential skills must a person acquire to be a successful manager?
3. Leaders and managers: A good leader may be an ineffective manager, while a good manager may become an insipid leader. This is the difference: A good manager must make the trains run on time, while a good leader determines where the train is headed and the nature of the freight carried.
4. Job satisfaction: A persistent problem in the working world is how to

increase pleasure at work.

5. Empowerment: When authority and opportunity are given to employees along with resources that these privileges require, employees respond positively. Empowerment gives the employee more freedom to make decisions about the job and its responsibilities. Empowerment works by showing the employee that management has faith and belief in ability and integrity. This inspires the employee to prove that this belief and faith were not misplaced. Does all of this not sound like a good child-rearing practice?

Advice to parents

1. Tell your children what you did at work today. Tell them about some tough situation you found yourself in and how you handled it. Ask how they would have handled it. Show your children, selectively of course, things you've written, such as memos or sales plans, and then involve them in your work life the way you are involved with their activities.
2. Try empowerment on them. You won't be sorry. ■

Robert Perloff, Ph.D., is a distinguished professor emeritus of business administration and psychology in the Katz Graduate School of Business, at the University of Pittsburgh. He is a past president of the American Psychological Association, and fellow in the Society for Industrial and Organizational Psychology.

Girls Choir

from page 1

present in singing, but also present in our lives. Do we say what we really feel and think? If it's not part of the public conversation, then it's secret."

The success of the Girls Choir of Harlem is no secret, and it illuminates key criteria for assisting young girls in making the difficult transition to adulthood.

Founded in 1979 by Walter J. Turnbull, Girls Choir of Harlem seeks to help young women transform their lives through music, build self-esteem, find positive role models, and develop a strong value system of discipline and hard work.

Three hundred students in grades 4 to 12 comprise the Girls Choir of Harlem. They attend the Choir Academy of Harlem, a co-ed public school with a full academic curriculum structured by the Board of Education. The program includes conservatory quality artistic instruction and performance opportunities, academic education, and such student support services as counseling, tutoring and college prep. Choir rehearsal is mandatory at the end of the academic day, from 2:30 to 6 PM for grades 9 to 12.

Under the direction of Lorna Myers, the performing arm of the Girls Choir consists of about 50 girls in grades 9 to 12 selected on the basis of excellence in academics, conduct, commitment, dependability, and full knowledge of the repertoire.

The program provides the girls — who are primarily Afro-American and Latino and come from Harlem and the neighboring communities — with a safe, secure and consistent environment. Seventy-five percent of the girls are from single parent families; 55 percent are living below poverty level; and 90 percent are considered "at risk" of dropping out of high school.

The Choir also provides opportunities to engage in meaningful activities where the girls can be success-

'Reducing prejudice' strategies practical, detailed

Psychologists have written recommendations for reducing prejudices that are individual-oriented and that help participants recognize inconsistencies among their values and behaviors that lead to negative emotions such as guilt. The recommendations include interventions consisting of intergroup contact among participants, focusing on cooperation within the group, and increasing awareness about negative racial feelings and beliefs.

The recommendations revolve around the "Common-In-Group Identity Model" to help participants deal with racist attitudes in a non-threatening manner.

For more information, see the American Psychological Association's *Current Directions in Psychological Science*, August 1999, volume 8, pp. 101-105. For reprints of the article, contact John F. Dovidio, Ph.D., Department of Psychology, Colgate University, Hamilton, NY 13346. E-mail: jdovidio@mail.colgate.edu.

For further information and a demonstration in which you can test your own racial attitudes using the Implicit Association Test, see Anthony Greenwald's website at "http://weber.u.washington.edu/~agg/ or via e-mail at agg@u.washington.edu.

ful. Artistic director Lorna Myers, a professional musician herself, expects a tremendous amount from each girl, both in terms of her behavior and musicianship. "I'm very strict. For instance, I have a specific dress code. It helps put them in a more disciplined mode. I make sure they stay very focused." Myers believes that such discipline opens the girls' eyes to the fact that their behaviors have consequences and helps to prepare them for life beyond the Choir.

"You must learn to make your own way to make an impact as an African-American person," Myers said, "but you have to be disciplined."

The relationship between Lorna Myers and the girls plays a critical role in the success of the program. The director and choir staff members serve as caring/ trusted adults who believe in the girls, stand by them, motivate them and push them to succeed. According to Gloria Hammond, M.D., a pediatrician for infants and toddlers at a neighborhood health center in Boston's South End and co-pastor with her husband at Bethel A.M.E. Church, such adults play an extremely important role in the lives of girls.

"There is a strong desire for role models," said Hammond, who participated in the discussion following the performance. "There's a need for consistent, continuous relationships. A girl might graduate from high school but should not from a relationship with a mentor. There is something in the culture that shuts down the dialogue. There needs to be a place for authentic, transparent conversation. Role models and mentors can help restore that."

The Girls Choir's public acclaim has given its members the opportunity to become role models themselves. According to Myers, with all their fame, the girls are most proud of the impact they have on girls outside the choir and the younger girls in the school.

"You can see it in the way they hold their heads walking down the hall in school. The fact that they are so empowered as to make a difference is great," said Myers. ■

Daniel Kertzner is a degree candidate in organizational behavior and management at Brown University, and a research assistant for the Presidential Seminar. He is a professional storyteller, and was an intern this past summer at the Institute on the Arts and Civic Dialogue at Harvard. He can be reached at Daniel_Kertzner@Brown.edu.

Youth have a right to know about reproductive health

Respecting people's right to information about reproductive health is essential if the world is to reduce sexually transmitted diseases, avoid early or unwanted pregnancies and control population growth, said World Health Organization director-general Dr. Gro Harlem Brundtland.

"Young people especially, as they embark upon their sexual and reproductive lives, must be able to protect themselves from disease, abuse and exploitation," Brundtland told a follow-up session to the International Conference on Population and Development (ICPD) at the United Nations. "They have a right to information and to services."

Every year, there are 333 million new cases of curable sexually transmitted diseases (STD), and one in 20 adolescents contracts an STD. More than 5.2 million people are infected by the HIV virus every year, over half of them young people less than 24 years old. In addition, thousands of young people become pregnant unintentionally. "Many of them risk their lives and health through recourse to unsafe abortion; many more find their future hopes dashed as they are obliged to leave school," Brundtland said.

According to Brundtland, the most effective way to prevent these problems is to address the needs of young people in a comprehensive way. "Young people need and want adult support and help in all aspects of growing up, whether in terms of their access to education and employment, or in terms of avoiding high-risk behaviors such as smoking, alcohol and illicit drug use, and unsafe sex," she said.

"Giving young people information does not encourage promiscuity, rather it fosters mutual respect and shared responsibility," Brundtland insisted.

In her speech, Brundtland listed two other key challenges that must be addressed if population growth is to stabilize. "The first is the challenge of combating poverty, the central challenge to development," she said. "People become ill because they are poor. And they become poor because they are ill." The last challenge is the urgent need to save all pregnant women from death and disability due to pregnancy.

"The majority of poor women in developing countries do not have the assistance of a skilled health care provider during labor and delivery," Dr. Bruntdland said. "This is the most important single intervention needed. This is not a luxury but a key indicator of development."

Guest Commentary

Predicting and preventing violence

By Allen J. Brown, J.D., Ph.D.

The tragic shooting deaths at Columbine High school in Littleton, Colo., and other highly publicized incidents in which a student or students murdered fellow students have led to renewed questions about violence. People struggle to understand how such incidents can happen in suburban schools. Psychologists can help in this process by placing the incident in context and explaining what is known about the prediction and prevention of violent behavior.

Because these events receive such tremendous media attention, we need to remind others and ourselves that school violence, such as the Littleton massacre, is extremely rare. The latest national statistics reveal that the violent crime rate, including youth crime, has steadily decreased over the past seven years. In fact, the rarity of violent behavior makes it exceedingly difficult to study, predict and prevent.

It is not possible to predict with certainty whether a particular individual will engage in an act of violence. However, it is possible to assess an individual and her or his environment and estimate the relative probability that that he or she will engage in a specific act of violence in the near future. This is done by evaluating the person and his or her environment to determine whether — and to what degree — factors that we know to be associated with an increased risk of violence are present.

One useful way of conceptualizing the causes of violence is to examine the predisposing, disinhibiting and inhibiting factors associated with an increased risk of violence.

Predisposing factors are proclivities or inclinations toward violence. They are considered internal variables or factors, i.e., they are enduring characteristics of the individual that make that person have a tendency to behave in a certain manner. For example, predisposing factors include: poor impulse control; low frustration tolerance; racism or other extremist beliefs; hatred; certain psychological traits such as narcissism, lack of empathy, antisocial tendencies, a history of violent behavior and/or abuse; social alienation; societal acceptance of violence as a means of dispute resolution; and certain psychiatric diagnoses.

Disinhibiting factors act as triggering mechanisms for setting off violence. For example, even individuals who are at high risk for becoming violent do not do so constantly. Conversely, given sufficient provocation, anyone is capable of violence. Some factor "triggers" them to engage in violence. A common disinhibiting factor is intoxication. Other common triggers include anger, anxiety, frustration, humiliation, access to instruments of violence (e.g., guns), societal acceptance of violence as a means of dispute resolution, perceived provocation and a sense that non-violent alternatives do not exist.

Inhibiting factors act to prevent the individual from becoming violent. Inhibiting factors include but are not limited to: personal morality; good impulse control; knowledge of ways to deal with frustration and other painful effects in a nonviolent manner; the presence of a non-violent process for the redress of grievances; lack of access to instruments of violence; supervision; and the fear of retribution.

Some factors serve as both predisposing and disinhibiting factors. Also, predisposing, inhibiting and disinhibiting factors work in concert. Behavior is thus multiply determined. For example, if an individual's predisposition is sufficiently strong, only a slight disinhibiting factor is necessary. Alternatively, if the predisposition is weak, a stronger trigger will be necessary. A similar type of analysis is applicable to inhibiting factors.

My knowledge of the Littleton assailants is limited to what has been reported in the popular press; thus it is incomplete and probably biased. Predisposing factors reportedly present included racism, hatred, a history of antisocial behavior, lack of empathy and social alienation. Disinhibiting factors included hatred, frustration, humiliation, access to instruments of violence, and an apparent lack of parental supervision.

The complexity of this conceptualization of violence helps to explain why it is so difficult to predict who will be violent in what circumstances. However, this model also suggests some things of which we need to be aware in our attempts to predict and reduce violence.

In general, individuals who exhibit predisposing factors are at greater risk for violence and may be helped through targeted interventions to address these risk factors. Interventions that minimize predisposing and disinhibiting factors and maximize inhibiting factors are most likely to result in the reduction of violence.

The focus must be on the environment and society rather than exclusively on the individual. ■

Allen J. Brown, J.D., Ph.D., is a clinical and forensic psychologist, clinical neuropsychologist and attorney. He is the Director of Adult Forensic Psychological Services for Brown, Pliner & Associates. He is also on staff at Massachusetts General Hospital and on the faculty of Harvard Medical School. Dr. Brown can be contacted at Abrown@hms.harvard.edu

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Psychological Assessment

Standardized checklists obscure contextual determinants of child behavior

By Audrey L. Zakriski, Ph.D., and Jack C. Wright, Ph.D.

When a child experiences emotional and behavioral problems that interfere with normal functioning, a psychological assessment is often requested. As a typical first step in the assessment process, a psychologist would have a teacher or parent complete a standardized child behavior checklist. In a thorough assessment, this would only be the beginning, and a more detailed analysis of the problem behavior would follow. Regardless of what follows, however, the scale scores that are derived from the standardized checklist may influence how a clinician initially conceptualizes a child's difficulties and may become part of a child's clinical file or subsequent written assessment.

Our recent research on standardized child behavior checklists suggests that they are problematic because they systematically obscure information about the social context in which children's behavior occurs. Important information about the meaning of the child's behavior problems, and situational factors contributing to the child's difficulties, are lost, potentially contributing to the conclusion that the behavior problem is "in the child" rather than being a product of both the child's behavior

Care should be taken to obtain the detailed contextual information that gives meaning to a child's behavior problems in follow-up interviews.

(turn to 6)

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Inside This Issue

Decreased length of postnatal stay does not result in increased rehospitalization *See page 3*

Mortality rates in young men are affected by alcohol *See page 3*

Moms use limit setting more often than other disciplinary practices *See page 4*

***Guest Commentary:* It's time to raise children out of poverty** *See page 8*

This month's client handout:
Tasks children can do to learn responsibility

Infant Development

Infants may perceive the emotional message in music

By Elizabeth A. Nawrot, Ph.D.

Research in progress with seven- and eight-month-old infants suggests that music's emotional message may be perceived at an early age.

Over the last twenty years, developmental psychologists have discovered that infants have quite sophisticated perceptual abilities. By five months of age, babies can discriminate the facial features that specify particular emotions and can categorize emotional tone across different faces. Infants' auditory perception is similarly attuned to socially relevant signals. Newborns show preferences for those that are presented with corresponding facial expressions. But does a preference for or a discrimination of a particular emotional expression demonstrate that the infant understands his or her social significance?

In this research, infants were required to demonstrate a meaningful response to visual and auditory expressions of emotion. Rather than using vocal emotional expressions, however, infants in this experiment

(turn to 5)

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

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Keep Your Eye On

... preterm birth risks.

A study was conducted to determine if gestational age at the time of preterm delivery is correlated with gestational age in successive preterm deliveries and whether changes in smoking habits influence the subsequent risk of preterm delivery. Investigators evaluated the associations among smoking habits of pregnant women who had a very preterm or moderately preterm delivery (before 32 weeks and at 32 to 36 weeks) and the risk of a subsequent very preterm or moderately preterm delivery. The study was carried out among 243,858 Swedish women between 1983 and 1993.

Women who had a previous very preterm delivery were more than 12 times as likely to have a very preterm or moderately preterm delivery in a subsequent pregnancy than women who had a previous term delivery. Women who had a previous moderately preterm delivery were more than seven times as likely to have a very preterm or moderately preterm delivery in a subsequent pregnancy. Women who smoked were less likely to have very preterm or moderately preterm babies, but women who quit smoking between pregnancies were not at increased risk for very or moderately preterm delivery.

The investigators conclude that the risk of very preterm delivery in successive pregnancies is increased most in women with a previous very preterm delivery, but that smoking habits also influenced the preterm delivery risk as well. (*The New England Journal of Medicine*, September 23, 1999. For more information, contact Sven Cnattingius, Department of Medical Epidemiology, P.O. Box 281, Karolinska Institute, SE-171 77 Stockholm, Sweden.)

... quality family life.

The kind of family a child comes from is much more important to the child's development than whether or not the child is in some type of nonmaternal child care, according to an expert in human development and family study. Jay Belsky, Ph.D., distinguished professor of human development at Pennsylvania State University in University Park is collaborating with the National Institute of Child Health and Human Development (NICHD) to study early child care. The study is a large investigation of more than 1,000 children and their families.

Belsky reports that the NICHD research indicates that characteristics of family life appear to exert a stronger and more consistent influence on all aspects of child functioning during the first three years of life than child care does.

"Strong economic resources and parent education provide children with developmental advantages," says Belsky. "Other factors in families that may exert good influences are mothers who are psychologically healthy ... and parents who are more sensitive, responsive and emotionally available to their children. Their children function much better socially, emotionally and cognitively through the first three years than those who grow up in less economically and psychologically healthy families." (*American Medical Association.*) For more information, contact Amy Fox, AMA, 515 North State St., Chicago, IL 60610. Telephone: (312) 464-4843. Or, e-mail Jay Belsky at j.belsky@psychology.bbk.ac.uk.

... tobacco and youth.

To learn how underage youth have been regarded by the major tobacco companies, documents from the Brown & Williamson Tobacco Corp. and others were evaluated by Cheryl A. Perry, Ph.D., an epidemiologist at the University of Minnesota in Minneapolis. The documents were obtained from a 1998 lawsuit by the state of Minnesota against Philip Morris Inc. Perry found that youths are "critical" to tobacco companies, and that most adult smokers begin smoking as underage teens.

Only 18 percent of smokers begin smoking at 18 years of age, and 5 percent begin smoking at age 21 or older. "Thus, early through middle adolescence is the developmental stage during which smoking onset occurs," according to Perry. Some tobacco companies reported that the major growth market was among teens. For example, R.J. Reynolds Tobacco Co. reported that its 1990 "Joe in Action" Camel advertising campaign "helped realize tangible increases as a [first usual brand of cigarettes]" among underage youths.

All the major tobacco companies reported successful youth brand campaigns during the last 25 years for cigarettes such as Kool, Marlboro, Camel and Newport. Marlboro remains the dominant seller in the youth market because of its "uncalculatedly right" image for autonomy-seeking adolescents, Perry notes. She recommends that the tobacco industry should be "closely scrutinized and monitored," because it depends on underage youths to replace smokers who quit or die. (*Archives of Pediatrics and Adolescent Medicine* 1999; 153:935-941. For more information, contact Cheryl L. Perry, Ph.D., Division of Epidemiology, University of Minnesota, 1300 S. Second St., Suite 300, Minneapolis, MN 55403. E-mail: perry@epivax.epi.umn.edu.)

What's New in Research

How safe is early discharge for newborns?

A study to determine the impact of decreasing postnatal length of stay on rehospitalization rates in the immediate postdischarge period for Medicaid neonates was conducted. The retrospective, population-based group was based on Ohio Medical claims data that were linked to vital statistics files from 1991 to 1995. A total of 102,678 full-term neonates who were born to mothers receiving Medicaid for at least 30 days after birth were evaluated.

The main outcome measures of the study were rehospitalization rates within seven and 14 days of discharge, postdischarge health care use, and regional variations in length of stay and rehospitalization.

Over the course of the study, the proportion of neonates who were discharged following a short stay of less than one day after vaginal delivery and less than two days after cesarean birth increased by 185 percent, from 21 percent to 59.8 percent. The average length of stay decreased by 27 percent, from 2.2 to 1.6 days.

The proportion of neonates who received a primary care visit within 14 days of birth increased by 117 percent, but rehospitalization rates within seven and 14 days of discharge decreased by 23 percent. The drop in rehospitalization rates was attributed to better postdischarge coordination of care in the population, such as primary care and home health visits.

Factors significantly associated with increased likelihood of rehospitalization within both seven and 14 days of discharge included being white, having a shorter gestation, primiparity (first birth), earlier year of birth, lower five-minute Apgar score, and having a vaginal delivery.

A primary reason for rehospitalization was jaundice, accounting for 42 percent of hospitalizations within seven days, but readmission rates for jaundice did not significantly change during the four years of the study. The second most common reason for rehospitalization was respiratory problems, followed by fever, infections, disorders of the digestive system, bronchiolitis, dehydration, and feeding problems.

The authors conclude that although their study found that decreases in postnatal length of stay were not associated with an increase in rehospitalizations, the shift to outpatient care may explain why fewer patients were hospitalized for problems.

Kotagal UR, Atherton HD, Eshelf R, et al.: Safety of early discharge for Medicaid newborns. *Journal of the American Medical Association* 1999; 282:1150-1156. For reprints, contact Ulma R. Kotagal, MBBS, Msc, Children's Hospital Medical Center, 3333 Burnet Ave., Cincinnati, OH 45229-3039.

Mortality rates in young men are affected by alcohol

A study conducted in 1969 and 1970 on young men born between 1949 and 1952 sought to analyze the association between alcohol consumption and the incidence of myocardial infarction (heart attack), stroke, and mortality in a 25-year follow up of military recruits.

Investigators used two questionnaires with questions regarding social background, behavior, and use of alcohol and tobacco. Participants also met with a psychologist for assessment.

The study outcomes were total mortality (1,473 men) and incidences of myocardial infarction (279 men) and stroke (233 men) as underlying causes of death or as main diagnoses during hospitalization.

Compared with men who abstained from alcohol, alcohol consumers had higher unadjusted relative risks for all three outcomes, and risks increased with higher alcohol consumption. Risks were highest for men who consumed more than 15 grams of ethanol a day. Adjusted analyses showed an increasing significant risk of death and an insignificant increased risk of stroke with increasing alcohol consumption. However, there was an insignificant decreasing risk of myocardial infarction.

In addition, increased mortality with high alcohol consumption was related to the strong association between drinking and smoking; smokers with high alcohol consumption had a three- to five-fold increased risk of death, depending on the number of cigarettes smoked per day.

There was a "cardioprotective" effect found in young men who used alcohol, possibly from factors associated with alcohol intake such as a decrease in platelet coagulability. However, the authors note that there was a clear association found between the level of alcohol use and risk of subsequent hospitalization or death with a diagnosis of alcoholism, alcohol psychosis or alcohol intoxication.

They conclude their findings "clearly indicated that alcohol consumption had a negative net effect on the subjects' health up to the age of 45," and that "the results support a restrictive alcohol policy and recommendations for little or no alcohol consumption by young men."

Romelsjo A, Leifman A: Association between alcohol consumption and mortality, myocardial infarction, and stroke in a 25-year follow up of 49,618 young Swedish men. *British Medical Journal* 1999; 319:821-822. For reprints, contact Anders Romelsjo, Associate Professor, Karolinska Institute, Department of Public Health Sciences and Centre for Alcohol and Drug Prevention, Novum, S-141 57 Huddinge, Sweden.

Group asking for community support to prevent suicide

The Suicide Prevention Advocacy Network (SPAN) USA is a national grassroots organization that helped developed The Surgeon General's Call to Action to Prevent Suicide 1999. Suicide is the nation's eighth leading cause of death, and is among the top three causes of death in young people. More Americans are likely to die from suicide than by homicide — more than 30,000 people each year.

SPAN USA is asking for support from the community to get the word out. For more information, contact SPAN USA, 5034 Odin's Way, Marietta, GA 30068. Telephone: (888) 649-1366. E-mail: www.spanusa.org.

Limit setting the most common discipline

Investigators conduced a cross-sectional survey to describe maternal discipline of children in at-risk families in North Carolina and to determine the factors associated with disciplinary practices. Participants were caregivers of 7- to 9-year old children with factors at birth that placed them at risk for abuse.

A total of 186 maternal caregivers (not all were the biological mothers of the children) interviewed were assessed for their disciplinary practices for five different misbehaviors. The most common practice for four of five misbehaviors such as lying and stealing was limit setting, which was reported by 63 percent of mothers. Spanking was more likely to be used as a secondary response when the primary response had not succeeded. However, the mothers reported that teaching or verbal assertions was always less likely to be successful as a secondary response.

Teaching or verbal assertion was used more for lying than for other misbehaviors, but limit setting was more common for disobeying, spanking was more common for stealing, and spanking with an object was more common for being disrespectful. Teaching or verbal assertion was more likely to occur with mothers of black race, who did not have Aid to Families with Dependent Children, who had more education, and who had a female child. Having a biological father in the home was associated with higher use of teaching or verbal assertion as well.

"As we continue to learn about discipline, it will be important to learn more about what is effective in the short-term, and the ways in which discipline practices affect long-term child outcomes such as prosocial behavior, self-esteem, conscience, and aggression," the authors conclude.

Socolar RRS, Winsor J, Hunter WM, et al.: Maternal disciplinary practices in an at-risk population. *Archives of Pediatrics and Adolescent Medicine* 1999; 153:927-934. For reprints, contact Rebecca R.S. Socolar, M.D., MPH, CB 7225, Community Pediatrics, University of North Carolina, Chapel Hill, NC 27599-7225.

Tasks children can do to learn responsibility

Children learn responsibility by being responsible. Sometimes parents only give children tasks that relate to the child's personal effects, such as picking up their belongings. One of the best ways you can teach your child helpfulness is to provide opportunities for him/her to contribute to the family. However, it's important not to give him/her only the "low dignity jobs," such as taking out the garbage and cleaning up the dog's messes.

The following is a list of age-appropriate tasks. The list is by no means complete, but serves as a guide for parents who may not know just how much their children can contribute from an early age.

18 months-3 years old

- Turn off lights while being carried.
- Carry in the newspaper or mail.
- Get own cereal or snack from kid-friendly containers.
- Pick up toys and clothes.
- Wash tables and counters with damp sponge.
- Put soiled or wet diaper in the diaper pail.
- Wash vegetables, tear lettuce, stir.
- Help set the table.
- Feed and water pets.
- Help clean up after meals and play.
- Wake up siblings.
- Run simple errands around the house.
- Help put groceries away.
- Carry in light groceries.
- Scramble eggs, make toast.
- Help make beds.
- Put plastic dishes in the dishwasher.
- Make salads.
- Bring recyclables to the garage.
- Lead family prayers.
- Put own clothes away. Take clothes out of the dryer.
- Tell you when the traffic light turns green.
- Clear dishes from table.
- Seal and stamp envelopes.

4-6 years old

All of the above, plus:

- Help find grocery items in the store.
- Help fold towels and wash clothes.
- Pour things.
- Give you a back rub or foot rub.
- Help measure ingredients.
- Count goods at the grocery store.
- Water plants.
- Sort white clothes from dark clothes for laundry.
- Help with vacuuming, sweeping and dusting.
- Take library books and videos to and from car.
- Put gas in your car.
- Help younger siblings.
- Help plant a garden.
- Wash the floor.
- Put dishes in the dishwasher.
- Measure soap for dishwasher and start cycle.
- Be responsible for compost buckets.
- Haul things in the wagon.
- Assist in meal planning.
- Make a simple meal.
- Empty dishwasher and stack dishes on counter.
- Rake leaves for short periods of time.
- Help wash pets.
- Prepare own lunch.
- Walk well-behaved pets.
- Carry in firewood.
- Start to manage own money.

(Continued, over ...)

7-10 years old

All of the above, plus:

- Get him/herself up in the morning.
- Help wash and vacuum car.
- Wash dishes.
- Fix snacks and light meals.
- Help read recipes.
- Run washing machine and dryer.
- Change sheets on bed.
- Help with projects around the house.
- Address and stuff envelopes.
- Read to younger siblings.
- Bathe younger siblings.

11-15 years old

All of the above, plus:

- Baby sit.
- Cook meals.
- Buy groceries from a list.
- Wash windows.
- Change light bulbs.
- Make appointments.
- Order out for family.
- Wax car.
- Mow lawn.
- Operate saws for home projects.
- Help in parent's business.

16-18 years old

All of the above, plus:

- Run errands.
- Balance family check book.
- Handle their own checking account.
- Maintain car.
- Help with family budgets.
- Take care of house/garden/yard.
- Take care of animals.
- Help younger children with homework.
- Take care of siblings.

Adapted with permission from *Redirecting Children's Behavior* by Kathryn J. Kvols (Parenting Press Inc., Seattle, WA). 1998. For more information, or to order the book, call (800) 992-6657.

The Brown University **Child and Adolescent Behavior Letter**

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Infant Development

from page 1

listened to musical passages. Adults and even young children can readily interpret emotional themes from music, so perhaps the message is available even to novice listeners such as infants.

With little or no experience associating musical structure with emotional experiences, the ability to interpret adult-like emotional messages from unfamiliar music might suggest the existence of an amodal, innate mechanism for detecting socially important communication beyond language or gestures.

Each piece of music was chosen to reflect a particular emotion — happy, sad, angry or fearful. However, rather than assume that an adult's perception of emotion from a particular piece of music would also reflect an infant's interpretation, I based the musical selections on the interpretations of very young children. In an experiment with three- to five-year-olds, the children were required to choose which of five photographed facial expressions (happy, sad, angry, fearful or neutral) "went with" a particular piece of music. Their choices were compared to a group of adult listeners.

The preschoolers demonstrated significant consistency in their matches, despite often making different choices from the adults. For example, a passage from Mozart's Violin Concerto Number Two elicited the most consistently "happy" choices from preschoolers and so this piece was used as the happy music in the infant experience.

Using an intermodal matching paradigm, 18 seven- and eight-month-olds were presented with two videotaped dynamically modeled facial emotions, side-by-side, while they listened to a single passage of classical music. In the videotape, the female actress (the same model whose photographed facial expressions were used in the preschool experiment) was instructed to "tell a happy story" or "tell a sad story." Experimental biases were reduced with multiple trials that counterbalanced the side of the videotapes and the order of the music. In addition, parents wore headphones that prevented them from hearing the music, and the infants' responses were recorded and scored by an observer who was blind to both videotape position and musical condition.

When it comes to the perceptual mechanisms themselves, research has shown the infants' and adults' perceptual processes are very similar.

Overall, the infants demonstrated a significant preference to look towards the happy expression. However, when separated by age, the data revealed that the seven-month-olds actually switched their looking preferences to the affectively matching music, preferring to look at the happy expression when accompanied by the happy music and the sad expression when accompanied by the sad music. In fact, six of the seven younger infants showed this trend while only one of the older infants strayed from their happy preference.

The facial and musical stimuli did not share any obvious structural or temporal synchrony (the actress posing the emotions never even heard the music), so what could the basis of the seven-month-olds' ability to connect these seemingly unrelated pairs of visual and auditory stimuli? Perhaps the infants were detecting a common tempo across the visual and auditory modalities; a quick beat was matched to a gregarious and excited happy face whereas a slow beat specified the dull, sad face. A simple comparison between a happy and angry emotion will help to test this possibility as these emotions share agitated movement and fast pace across the visual and auditory modalities. If infants are able to discriminate between happy and angry in this intermodal matching experiment, it might suggest that they are detecting something more meaningful in these pairs of socially relevant visual and musical stimuli: An emotional message that not only transcends the modality but is communicated through a rich, yet non-linguistic medium.

While it is clear that infants have both a need for and an ability to detect the social significance of language (regardless of the particular language, spoken or not), it is not clear if and when the emotional message of music, so obvious to many adults and young children, becomes a vehicle for communication to infants.

When it comes to the perceptual mechanisms themselves, research has shown the infants' and adults' perceptual processes are very similar. Speech, music, and even color preferences and categories develop in predictable ways. Certainly these similarities are the result of a physiological timetable for development. But does nature simply program the infant to seek out advantageous social stimuli, or does the infant really understand their meaning? After all, language, culture and experience surely act to tune preference and perception. Perhaps the older infants in this study simply preferred the happy expression as a result of more experience and familiarity. But the music of a non-Western culture need not use the familiar fast tempo or major chord to accompany a happy expression.

Yet despite linguistic and cultural differences, any parent can tell you how a lullaby will soothe a fussy baby. And psychologists now know that the songs we sing to our babies share many similarities, regardless of language or culture. It seems as if parents the world over were given the ability to communicate emotion to their infants through their faces, their voices and their songs. Why the shouldn't infants have the ability to comprehend these messages? The face, the voice, and perhaps music too, send a powerful message of emotion from parent to child that both the sender and receiver have been designed to use and comprehend. ■

Elizabeth S. Nawrot is assistant professor of psychology at Moorhead State University, Moorhead, MN. For more information, contact Dr. Nawrot at (218) 236-4079; e-mail: nawrot@mhd1.moorhead.msus.edu

Checklists

from page 1

and the surrounding social environment.

Child behavior checklists are widely used in both research and clinical practice, and therefore may have a broad influence on how people think about child psychopathology. Publicity for one of the most popular of these checklists indicates that it has been used in more than 2,400 studies by more than 4,500 investigations.

Although the details of the different child behavior checklists vary, in essence the teacher or parent is asked to indicate how often a child displays a number of problem behaviors over a period of several months. For example, the respondent might be asked to summarize how often the child cries, whines, hits or threatens other people. Using standardized scoring procedures, the ratings for related items are averaged to form "scale scores,"(e.g., aggression, withdrawal), which are then compared to national norms based on large samples of children.

Authors of these inventories suggest that filtering out situational variation is one of their major strengths. However, others suggest that this is one of their greatest weaknesses and prefer to emphasize the complex combination of child and environment factors that can contribute to child psychopathology.

Context adds understanding

An example illustrates one of the main concerns raised about child behavior checklists from this contextual point of view:

Kyle and Sheryl are similar in their overall frequency of displaying aggression. However, when we assess context, we learn that Kyle is aggressive when threatened, whereas Sheryl is aggressive when talked to in a friendly way.

Although the causal factors related to these children's aggressive behavior are likely to be different, and different interventions probably would be needed, aggression scale scores do not detect this patterning difference and could indicate that Kyle and Sheryl are equally aggressive.

The problem illustrated by this hypothetical example was demonstrated in a recent study conducted in a summer residential treatment program for children with emotional and behavioral problems.

Children were divided into commonly studied clinical groups using a popular child behavior checklist. These groups were formed by identifying those children who were high or low on two broad behavior problem scales: "Internalizing"(a composite score of withdrawal, anxiety/depression, and somatic complaints) and "Externalizing"(a composite score of aggressive and delinquent behavior).

Externalizing children were high on externalizing only, Internalizing children were high on internalizing only, and Mixed (or "comorbid") children were high on both. The latter group is of special interest because they are at heightened risk for subsequent psychological problems. Based on their scale scores alone, one might expect that Mixed children simply display high rates of externalizing behavior (like the Externalizers) and high rates of internalizing behavior (like the Internalizers). However, when we examined how these groups of children responded in different social situations, we found important differences in the contexts that elicited their aggressive or withdrawn behavior, differences that were obscured by their similar scale scores.

Externalizing children showed a specific pattern of elevated aggression in response to aversive events (e.g., adult warning). Internalizing children showed a specific pattern of elevated withdrawal in response

Recommended Reading: Expanded Section

Many books of obvious interest to this newsletter's readers have been received in the Editor's office. We take this opportunity to help you, our subscribers, catch up on your outside reading.

Children of Trauma: Stressful Life Events and Their Effects on Children and Adolescents — *T. W. Miller (Ed.) Madison, CT: International Universities Press, 1998, $42.50 (hardcover), 267 pages. (800) 835-3487.*

Handbook of Autism and Pervasive Developmental Disorders — *D.J Cohen & F.R. Volkmar (Eds.) New York: Wiley, 1997, $125 (hardcover), 1,092 pages. (800) 225-5945.*

Defiant Teens: A Clinician's Manual for Assessment and Family Intervention — *Barkley, R.A., Edwards, G.H. & Robin, A.L. New York: The Guilford Press, 1999, $30 (softcover), 250 pages. (800) 365-7006.*

The Construction of the Self: A Developmental Perspective — *Harter, Susan. New York: The Guilford Press, 1999, $42 (hardcover), 413 pages. (800) 365-7006.*

Betrayed as Boys: Psychodynamic treatment of sexually abused men — *R.B. Gartner. New York: The Guilford Press, 1999, $40 (hardcover), 356 pages. (800) 365-7006.*

Ritalin is not the Answer: A Drug-free, Practical Program for Children Diagnosed with ADD or ADHD — *David B. Stein. San Francisco: Jossey-Bass, 1999, $15 (softcover), 203 pages. (415) 433-1767, ext. 596.*

Child Development: A Practitioner's Guide — *D. Davies. New York: The Guilford Press, 1999, $40 (hardcover), 412 pages. (800) 365-7006.*

Handbook of Attachment: Theory, Research, and Clinical Applications — *Jude Cassidy & P.R. Shaver (Eds.) New York: Guilford Publications, 1999, $85 (hardcover), 925 pages. (800) 365-7006.*

The Effectiveness of Early Intervention — *M.J. Guralnick. Baltimore, MD: Paul H. Brookes Publishing, 1997, $79 (hardcover), 665 pages. (800) 638-3775.*

The Case for Pragmatic Psychology — *D.B. Fishman. New York: New York University Press, 1999, $48 (hardcover), $16 (soft), 387 pages. (800) 996-6987.*

The Clinician's Practical Guide to Attention-Deficit/Hyperactivity Disorder — *M. Mercugliano, T.J. Power, & N.J. Blum. Baltimore, MD: Paul H. Brookes Publishing, 1999, $39.95 (softcover), 349 pages. (800) 638-3775.*

Conquering Schizophrenia: A Father, His Son, and a Medical Breakthrough — *Peter Wyden. New York: Alfred A. Knopf, 1998, $25 (hardcover), 335 pages. (212) 751-2600.*

Queer Kids: The Challenges and Promise for Lesbian, Gay, and Bisexual Youth — *Robert E. Owens, Jr. New York: Harrington Park Press (Haworth), 1998, $49.95 (hardcover), $24.95 (soft), 355 pages. (800) 429-6784.*

The Child with Special Needs: Encouraging Intellectual and Emotional Growth — *S.I. Greenspan & S. Wieder. Reading, MA: Addison-Wesley, 1998, $26 (hardcover), 496 pages. (Perseus Books, 781-944-3700).*

Treating the Tough Adolescent: A Family-based, Step-by-step Guide — *Scott P. Sells. New York: Guilford Press, 1998, $35 (hardcover), 320 pages. (800) 365-7006.*

Straight Talk about Psychiatric Medications for Kids — *Timothy E. Wilens. New York: Guilford Press, 1998, $29.95 (hardcover), $14.95 (softcover), 280 pages. (800) 365-7006.*

The Art of Psychotherapy: Case Studies from the Family Therapy Networker — *R. Simon, L. Markowitz, C. Barrilleaux, & B. Topping (Eds.) New York: John Wiley, $37.95 (softcover), 315 pages. (800) 225-5945.*

Assessing Adolescents with the Million Adolescent Clinical Inventory — *Joseph T. McCann. New York: Wiley, 1999, $55 (hardcover), 238 pages. (212) 850-6336. (800) 225-5945.*

The Harvard Medical School Guide to Suicide Assessment and Intervention — *D.G. Jacobs (Ed.) San Francisco: Jossey-Bass, $59.95 (hardcover), 704 pages. (415) 433-1767, ext. 596.*

Fatal Families: The Dynamics of Intrafamilial Homicide — *C.P. Ewing. Thousand Oaks, CA: Sage Publications, $65 (hardcover), $29.95 (softcover), 196 pages. (805) 499-9774.*

Entering the Child's Mind: The Clinical Interview in Psychological Research and Practice — *H.P. Ginsburg. New York: Cambridge University Press, 1997, $59.95 (hardcover), $19.95 (softcover), 277 pages. (800) 872-7423.*

Our Promise to Children — *Kathleen A. Guy. Ottawa, Canada: Canadian Institute of Child Health, 1997, $18.00 (softcover), 197 pages. (613) 224-4144.*

A Piaget Primer: How a Child Thinks (revised ed.) — *D.G. Singer & T.A. Revenson. Madison, CT: International Universities Press, 1996, $12.95 (softcover), 146 pages. (800) 835-3487.*

Escape from Poverty: What Makes a Difference for Children? — *P.L. Chase-Lansdale & J. Brooks-Gunn (Eds.) New York: Cambridge University Press, 1997, $49.95 (hardcover), $24.95 (soft), 325 pages. (800) 872-7423.*

No-Talk Therapy for Children and Adolescents — *Martha B. Straus, W.M. Bukowski, A.F. Newcomb, & W.W. Hartup (Eds.) New York, London: W.W. Norton & Company, 1999, $27 (hardcover), 242 pages. (800) 233-4830.*

A Guide to Possibility: Fifty-One Methods for Doing Brief, Respectful Therapy — *Bill O'Hanlon & Sandy Beadle. New York, London: W.W. Norton & Company, 1997, $13 (softcover), 86 pages. (800) 233-4830.*

On Playing a Poor Hand Well: Insights from the Lives of Those Who Have Overcome Childhood Risks and Adversities — *Mark Katz. New York, London: W.W. Norton & Company, 1997, $29.00 (hardcover), 187 pages. (800) 233-4830.*

Ritalin Nation: Rapid-fire Culture and the Transformation of Human Consciousness — *Richard DeGrandpre. New York, London: W.W. Norton & Company, 1999, $23.95 (hardcover), 284 pages. (800) 233-4830.*

Fetal Alcohol Syndrome: A Guide for Families and Communities — *Ann Streissguth. Baltimore, MD: Paul H. Brookes Publishing Company, 1997, $22.95 (softcover), 306 pages. (800) 354-9706.*

Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors — *G. Alan Marlatt (Ed.) New York: Guilford Publications, 1998, $40 (hardcover), 390 pages. (800) 365-7006.*

Cognitive-Behavioral Therapies for Trauma — *Victoria M. Follette, Josef I. Ruzek, & Francis R. Abueg (Eds.) New York: Guilford Publications, 1998, $40 (hardcover), 431 pages. (800) 365-7006.*

Children's Engagement in the World: Sociocultural Perspectives — *Artin Goncu (Ed.) New York: Cambridge University Press, 1999, $59.95 (hardcover), $21.95 (softcover), 269 pages. (800) 872-7423.*

Postpartum Depression and Child Development — *Lynne Murray & Peter J. Cooper (Eds.) New York: Guilford Publications, 1997, $35 (hardcover), 322 pages. (800) 365-7006.*

Psychologists on the March: Science, Practice and Professional Identity in America, 1929-1969 — *James H. Capshew. New York: Cambridge University Press, 1999, $59.95 (hardcover), 276 pages. (800) 872-7423.*

Essentials of Human Memory — *Alan D. Baddeley. United Kingdom: Psychology Press, 1999, $59.95 (hardcover), $29.95 (softcover), 356 pages. (800) 627-6273,*

Effective School Interventions: Strategies for Enhancing Academic Achievement and Social Competence — *Natalie Rathvon. New York: Guilford Publications, 1999, $35 (hardcover), 366 pages. (800) 365-7006.*

The Integrative Neurobiology of Affiliation — *Carol Sue Carter, I. Izja Lederhendler, & Brian Kirkpatrick (Eds.) New York: New York Academy of Sciences, 1997, $110 (hardcover), $40 (softcover), 614 pages. (800) 843-6927.*

The Developing Mind: Toward a Neurobiology of Interpersonal Experience — *Daniel J. Siegel. New York, London: The Guilford Press, 1999, $37.95 (hardcover), 394 pages. (800) 365-7006.*

Radical Behaviorism: Willard Day on Psychology and Philosophy — *Sam Leigland (Ed.) Reno, NV: Context Press, 1992, $29.95 (softcover), 208 pages. (888) 427-2665.*

Sexually Aggressive Children: Coming to Understand Them — *Sharon K. Araji. Thousand Oaks, CA: Sage Publications, 1997, $25.95 (softcover), 246 pages. (805) 499-9774.*

A Mother's Nightmare — Incest: A Practical Legal Guide for Parents and Professionals — *John E. B. Myers. Thousand Oaks, CA: Sage Publications, 1997, $24.50 (softcover), 246 pages. (805) 499-9774.*

Young Killers: The Challenge of Juvenile Homicide — *Kathleen M. Heide. Thousand Oaks, CA: Sage Publications, 1999, $24.95 (softcover), 299 pages. (805) 499-9774.*

Shadows in the Sun: The Experiences of Sibling Bereavement in Childhood — *Betty Davies. Philadelphia: Brunner/Mazel (Taylor & Francis Group), 1999, $59.95 (hardcover), 264 pages. (800) 825-3089.*

Emotionally Intelligent Parenting: How to Raise a Self-Disciplined, Responsible, Socially Skilled Child — *Maurice J. Elias, Steven E. Tobias, & Brian S. Friedlander. New York: Harmony Books, 1999, $22 (hardcover), 241 pages. (800) 773-3000.*

Coercion and Punishment in Long-Term Perspectives — *Joan McCord (Ed.) New York: Cambridge University Press, 1998, $59.95 (hardcover), $21.95 (softcover), 392 pages. (800) 872-7423.*

Things You Can Do for Our Children's Future — *Richard Louv. New York: Anchor Books, 1994, $10 (softcover), 355 pages. (800) 223-5780.*

Meaningful Differences: In the Everyday Experience of Young American Children — *Betty Hart & Todd R. Risley. Baltimore, MD: Paul H. Brookes Publishing Co., 1995, $26 (hardcover), 268 pages. (800) 638-3775.*

Treating Children with Sexually Abusive Behavior Problems: Guidelines for Child and Parent Intervention — *Jan Ellen Burton, Lucinda A. Rasmussen, Julie Bradshaw, et al. New York: The Haworth Maltreatment & Trauma Press, 1998, $49.95 (hardcover), $29.95 (softcover), 279 pages. (800) 342-9678.*

The Process of Parenting: Fifth Edition — *Jane B. Brooks. Mountain View, CA: Mayfield Publishing Company, 1999, $46.95 (softcover), 576 pages. (800) 433-1279.*

Handbook of Research Methods in Human Operant Behavior — *Kennon A. Lattal & Michael Perone (Eds.) New York: Plenum Publishing Corporation, 1998, $115 (hardcover), 669 pages. (800) 221-9369.*

The Vulnerable Child, Volume 3 — *Theodore*

B. Cohen, M. Hossein Etezady, & Bernard L. Pacella (Eds.) Madison, CT: International Universities Press, Inc., 1999, $52.50 (hardcover), 351 pages. (800) 835-3487.

THE TALENT FOR STUPIDITY: THE PSYCHOLOGY OF THE BUNGLER, THE INCOMPETENT, AND THE INEFFECTUAL — *Edmund Bergler. Madison, CT: International Universities Press, Inc., 1998, $37.50 (hardcover), 245 pages. (800) 835-3487.*

AMOROUS TURKEY AND ADDICTED DUCKLINGS: A SEARCH FOR THE CAUSES OF SOCIAL ATTACHMENT — *Howard S. Hoffman. Boston: Authors Cooperative, 1996, $16.95 (softcover), 194 pages. (800) 472-5425.*

THE CLINICAL CHILD DOCUMENTATION SOURCEBOOK (with disk) — *Donald K. Freedheim & Jeremy P. Shapiro. New York: John Wiley & Sons, Inc., $49.95 (softcover), 256 pages. (800) 225-5945.*

BRIEF CHILD THERAPY HOMEWORK PLANNER (with disk) — *Arthur E. Jongsma, Jr., L. Mark Peterson, & William P. McInnis. New York: John Wiley & Sons, Inc., 1999, $49.95 (softcover), 284 pages. (800) 225-5945.*

BRIEF ALCOHOL SCREENING AND INTERVENTION FOR COLLEGE STUDENTS (BASICS): A HARM REDUCTION APPROACH — *Linda A. Dimeff, John S. Baer, Daniel R. Kivlahan, & G. Alan Marlatt. New York: The Guilford Press, 1999, $25 (softcover), 200 pages. (800) 365-7006.*

DEFIANT CHILDREN, SECOND EDITION: A CLINICIAN'S MANUAL FOR ASSESSMENT AND PARENT TRAINING — *Russell A. Barkley. New York: The Guilford Press, 1997, $35 (hardcover), 264 pages. (800) 365-7006.*

THE ADOLESCENT EXPERIENCE: EUROPEAN AND AMERICAN ADOLESCENTS IN THE 1990s — *Francoise D. Alsaker & August Flammer. Mahwah, NJ & London: Lawrence Erlbaum Associates, Publishers, 1999, $45 (hardcover), 183 pages. (800) 926-6579.*

COPING WITH DIVORCE, SINGLE PARENTING, AND REMARRIAGE: A RISK AND RESILIENCY PERSPECTIVE — *Mavis Hetherington (Ed.) Mahway, NJ: Lawrence Erlbaum Associates, Publishers, 1999, $36 (softcover), 359 pages. (800) 926-6579.*

DSM-IV DIAGNOSIS IN THE SCHOOLS — *Alvin E. House. New York: Guilford Publications, 1999, $28.95 (hardcover), 230 pages. (800) 365-7006.*

CULTURE AND ATTACHMENT: PERCEPTIONS OF THE CHILD IN CONTEXT — *Robin L. Harwood, Joan G. Miller & Nydia Lucca Irizarry. York, PA: Guilford Press, 1995, $28.95 (hardcover), 169 pages. (800) 365-7006.*

EMOTIONAL DEVELOPMENT IN YOUNG CHILDREN — *Susanne A. Denham. York, PA: Guilford Press, 1998, $38.95 (hardcover), $18.95 (softcover), 260 pages. (800) 365-7006.*

HANDBOOK OF MENTAL RETARDATION AND DEVELOPMENT — *Jacob A. Burack, Robert M. Hodapp, & Edward Zigler (Eds.) Cambridge, United Kingdom: Cambridge University Press, 1998, $80 (hardcover), $29.95 (softcover), 764 pages. (800) 872-7423.*

PHONEMIC AWARENESS IN YOUNG CHILDREN — *Marilyn Jager Adams, Barbara R. Foorman, Ingvar Lundberg, & Terri Beeler. Baltimore, MD: Paul H. Brookes Publishing Co., 1998, $24.95 (spiral bound), 208 pages. (800) 638-3775.*

THE SOCIAL WORLD OF CHILDREN: LEARNING TO TALK — *Betty Hart & Todd R. Risley. Baltimore, MD: Paul H. Brookes Publishing Co., 1999, $65 (hardcover), $24 (softcover), 320 pages. (800) 638-775.*

BARBIE CULTURE — *Mary F. Rogert. Thousand Oaks, CA: Sage Publications, 1999, $21.95 (softcover), 171 pages. (805) 499-9774.*

CHILD MALTREATMENT: AN INTRODUCTION — *Cindy L. Miller-Perrin & Robin D. Perrin. Thousand Oaks, CA: Sage Publications, 1999, $66 (hardcover), $29.95 (softcover), 349 pages. (805) 499-9774.*

to aversive peer events (e.g., peer tease). Mixed children did not display either a blend or an average of these patterns for the two other groups; instead, they displayed a very distinctive pattern that consisted of elevated rates of aggression and withdrawn responses to positive events (e.g., friendly peer talk, adult praise). Thus, Mixed children were especially distinctive in the contexts in which they displayed their problem behavior, becoming aggressive and withdrawn in non-aversive situations, where the other groups were neither aggressive nor withdrawn.

Summarizing a child's behavior broadly over contexts obscures such information about the contextualized patterning of children's behavior, information that may be essential to the therapist, teacher or parent in designing effective interventions.

Differences appear same

A second hypothetical example highlights another kind of confusion that can result when the social context of a child's behavior problems is ignored:

Brandon and Kyle are similar in their overall frequency of displaying aggression. However, examination of contextual factors indicates that Brandon is teased frequently by peers, but is only occasionally aggressive when teased. Kyle, on the other hand, is rarely teased by peers, but is frequently aggressive when teasing does occur.

Intuitively and clinically, these children are fundamentally different: Brandon's aggressiveness appears more related to his hostile peer group, whereas Kyle's aggression is more related to how he responds to events. Nevertheless, the two children's checklist scale scores for aggression could be equivalent.

In a recent study we conducted with Kristen Lindgren in a special education setting, children who fit the descriptions of these hypothetical children were identified. Thus, the two groups differed both in their social environments and in how they responded: One group was frequently provoked, but was unlikely to respond aggressively when this occurred; the other group was provoked infrequently, but when this did occur they were likely to respond aggressively.

As expected, when teachers were asked to rate them using a standardized checklist, the checklist scale scores could not discriminate between these fundamentally different groups of children.

These findings were extended in a follow-up experiment in which participants read descriptions of fictitious children that resembled Brandon and Kyle. Interestingly, participants were quite sensitive to the differences between these targets in their social environments and their responses when we asked them directly. In some, rather than tapping people's knowledge of contextual factors, standardized instruments apparently lead them to ignore this information in order to produce simple (but contextually impoverished) scale scores.

As third-party reimbursement for comprehensive psychological evaluation decreases, it is likely that clinicians will be encouraged to rely on brief and inexpensive methods of assessment such as child behavior checklists.

There are several dangers associated with reliance on such methods. First, information about the social environment that is needed to interpret a child's behavior may be obscured. Second, this neglect of contextual factors creates the potential for misguided interventions that are based on measures of behavioral output rather than environmental factors that may contribute to the child's difficulties. Third, reliance on problem behavior scale scores could interfere with communication between the clinician and the teacher or parent who attend naturally to the contextual factors influencing a child's behavior problems. Fourth, child behavior checklists may reinforce the view that the problem or "syndrome" resides in the child.

In the short run, care should be taken to obtain the detailed contextual information that gives meaning to a child's behavior problems in follow-up interviews, and caution should be used before attributing the problem score to the child's individual difficulties.

In the long run, it will be important to develop a new generation of child behavior checklists that focus on child behavior problems and their social contexts. ■

Audrey Zakriski is an assistant professor of psychology at Connecticut College, alzak@conncoll.edu, and a licensed clinical psychologist in Rhode Island. Jack Wright is an associate professor of psychology at Brown University.

Recommended Reading:

Achenbach TM: *Empirically based taxonomy: How to use syndromes and profile types derived from the CBCL/4-18, TRF, & YSR.* Burlington, VT: University of Vermont Department of Psychiatry. 1993.

Wright JC, Zakriski AL, Drinkwater M: Developmental psychopathology and the reciprocal patterning of behavior and environment. *Journal of Consulting and Clinical Psychology* 1999; 67, 95-107.

Wright JC, Lindgren K, and Zakriski AL: Syndromal versus contextually sensitive assessment of child psychopathology: differentiating environmental and dispositional determinants of behavior. 1999. Manuscript under editorial review.

Guest Commentary

It's time to raise children out of poverty

By Marian Wright Edelman, President of the Children's Defense Fund

In the past two years in America, nearly 400,000 children joined the ranks of the extremely poor. Now there are 6.4 million children in families struggling to get by on incomes less than one-half of the poverty line. For a family of three, that's less than $6,400 a year. Think about what it must be like to try to feed, clothe and raise a family in the United States on such a small amount of money.

The bad news doesn't end there either. The number of poor children, 14.1 million, remains higher than it was at any time between 1966 and 1990. And, in 1997, a record number of working families with children were living in poverty.

Over the past few years, children in low-wage working families have been bearing the brunt of rising poverty, falling incomes, vanishing employer-paid health benefits, and a weakening safety net. When children grow up in poverty, they are more likely to perform poorly in school and are less likely to finish high school, let alone college. They are less likely to succeed as adults in earning a living wage or live up to their full potential for contributing to the rest of society.

When children grow up in poverty, they are more likely to perform poorly in school and are less likely to finish high school, let alone college. They are less likely to succeed as adults in earning a living wage or live up to their full potential for contributing to the rest of society.

There is some good news in the middle of all this despair. The American people want to help and they want to help now, according to a survey by the W.K. Kellogg Foundation. This poll clearly shows the American people think it's time for working families to get the support they need to provide for their children.

Statement of Ownership, Management and Circulation

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More than eight out of 10 Americans said the working poor, along with those who are trying to go from welfare to work, should be given help to raise their children out of poverty. The poll shows there is overwhelming support for assisting all low-income families with health coverage, quality child care, job training and more. It also shows that Americans want the federal and state governments to play a leading role in providing these supports.

For too long there's been a chasm between what the American people want and what they get from their leaders. It's grown bigger and bigger, just like the chasm dividing the rich from the poor in this nation. And it's our children who are falling into this abyss.

We must build the spiritual and political will to get children what they need to grow up healthy and ready to succeed. This is the time to make sure every child is given health coverage. This is the time to make sure every working family has access to affordable, quality child care if they need it.

At the same time we advocate for services that aren't available yet, we must also maintain strategic and sustained outreach to let working families know about the services that are out there for the, such as the state Children's Health Insurance Program (CHIP).

As Congress and the President debate how to use our remarkable budget surplus and as state legislators come together in the light of a very strong economy, they must consider the will of the American people. This nation needs to put children at the real, not the rhetorical, center of its priorities.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Sexual Identity

Know sexual identity, homosexual adjustment issues before counseling GLBT youth

By Arthur Lipkin, Ed.D.

Gay, lesbian, bisexual and transgender (GLBT) students have special problems growing up and keeping safe in environments that tend to be homophobic. Troubled GLBT youngsters confide in teachers and counselors they presume unlikely to be condemning. Sometimes just a passing expression of tolerance can indicate that one is open-minded: a poster on a wall, a book on the shelf, a word spoken against heterosexism.

Clearly, if the adult confidante is uncomfortable in such a role, he or she should refer the student elsewhere for gay-positive counseling, taking care to thank the young person for the trust. But when adults are open to the prospect, they should:

- Have a list of community resources available to GLBT young people.
- Be prepared to listen carefully.
- Be familiar with the issues.
- Know what questions to ask and when to do so.

Trained therapists are usually good listeners. But a student's distress can prompt a well-meaning counselor or teacher to jump in too soon with a "Hooray, you're

> ***Even the high-achieving young homosexual can feel like a fraud if his or her status is contingent on concealing a dark secret.***

*(See **GLBT Youth**, page 5)*

Vol. 15, No. 12 December 1999

Inside This Issue

Let's look again at dealing with pain in children with sickle cell disease *See page 3*

Witnesses to Oklahoma City bombing suffer long-term stress *See page 3*

Fighting, weapons carrying in adolescents is declining *See page 4*

Guest Commentary: GLBT youth need affirmations to balance cautions *See page 8*

This month's client handout:

Parenting teens: lessons from the Titanic

Practical Matters

Early experiences become building materials for the brain/mind

By Irving Lazar, Ph.D.

I would like to propose here a view of human growth in which the genes need to be compared to a database rather than a blueprint. In this model, the interactions within the dynamic field that include nutrition, infections, social stimuli and opportunities draw upon the individual's pool of genetic possibilities; but only those that are supported by environment are actualized.

Thus a useful assessment of the child's increasing complexity and adaptability cannot be based upon comparisons with age-mates or other groups of children, but needs to be based on scales of achievement of each of the component forces that affect successful interaction, adaptability and problem-solving.

In the beginning ...

Let's begin at the beginning. Imagine a relatively open system, chugging along and doing its thing, which mainly involves exchanging

*(See **Early Experiences**, page 6)*

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The Brown University **Child and Adolescent Behavior Letter**

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology,
Medical Science, and Human Development
at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine, private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

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Executive Editor: Gary A. Enos
Publisher Betty Rawls Lang
V.P. Finance: Paul J. Maloney, CPA
President: Fraser A. Lang

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What's New in Research

Assessing pain in children with sickle cell disease

Investigators from a midwestern children's hospital with a regional sickle cell disease (SCD) service say we should revise our previously held beliefs about the pain experiences of children with SCD and develop new ways to deal with this old problem.

The researchers examined the patterns of children's and caregivers' descriptions of pain and the comfort measures used to relieve the pain of SCD at home and in the hospital. A total of 21 African-American children aged six to 15 years old and their 21 caregivers were evaluated twice — first when a vaso-occlusive episode (VOE) occurred, and second without such an episode.

Different phases of the chronology of pain from a VOE were discovered during the study, with phase one being baseline, representing the usual state of the child's condition. Phases two to seven represented increasing, then decreasing, levels of pain. They found that a trip to the emergency department usually occurred during phase five, the point at which there was a peak pain experience. The child was usually discharged from the hospital at phase eight, when there was pain resolution.

The authors note that further studies should be done to determine when to treat children for pain to possibly avoid a trip to the emergency department. If pain treatment were provided earlier, it might be possible to avoid a VOE altogether, and the associated health problems such as stroke and acute chest syndrome.

"More immediate clinical issues that need to be addressed are those about the long duration and high intensity of the pain experienced by these children, the best ways to resolve this pain and the demands the pain places on the family system," the authors conclude. "Unrelieved pain produces suffering, which is perhaps much longer in duration than is necessary. Suffering may in turn have a negative effect on the lives of each family member in terms of school, marital relationships, employment, self-esteem, achievement and family function."

Beyer JE, Simmons LE, Woods GM, et al.: A chronology of pain and comfort in children with sickle cell disease. *Archives of Pediatrics and Adolescent Medicine* 1999; 153:913-921. For reprints, contact Judith E. Beyer, R.N., Ph.D., University of Missouri School of Nursing, 2220 Holmes St., Kansas City, MO 64108.

Lingering stress detected in children after Oklahoma

Researchers designed a clinical assessment to identify middle and high school students in need of formal evaluation for posttraumatic response symptoms following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, OK. A clinical needs assessment instrument was developed and administered to 3,218 children grades six through 12 at seven weeks after the bombing.

More than 40 percent of the students reported knowing someone who was injured in the bombing, and more than one-third reported knowing someone who was killed in the blast. Posttraumatic stress symptoms such as trembling/shaking or fast heartbeat at seven weeks were significantly correlated with gender, with girls reporting higher levels of symptoms than boys. Symptoms also were associated with exposure through knowing someone injured or killed and bomb-related television viewing.

"This study documents the intensity of community exposure to the bombing and the lingering symptoms of stress," the investigators conclude. The assessment was used in planning for clinical service delivery, training professional responders and supporting funding requests.

Pfefferbaum B, Nixon SJ, Krug RS, et al.: Clinical needs assessment of middle and high school students following the 1995 Oklahoma City bombing. *American Journal of Psychiatry* 1999; 156:1069-1074. For reprints, contact Betty Pfefferbaum, M.D., J.D., Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center, P.O. Box 26901, WP-3470, Oklahoma City, OK 73190-3048.

Recommended Reading

THE SCIENTIST IN THE CRIB: MINDS, BRAINS, AND HOW CHILDREN LEARN — *Alison Gopnik, Andrew N. Meltzoff, Patricia K. Kuhl. New York: William Morrow and Company, Inc., 1999, $24.00 (hard), 270 pages. (800) 356-0343.*

LIES! LIES! LIES!: THE PSYCHOLOGY OF DECEIT — *Charles V. Ford. Washington, D.C.: American Psychiatric Press, Inc., 1996, $16.00 (soft), 363 pages. (800) 368-5777.*

LONELINESS IN CHILDHOOD AND ADOLESCENCE — *Ken J. Rotenberg, Shelley Hymel. New York: Cambridge University Press, 1999, $59.95 (hard), 404 pages. (800) 872-7423.*

COGNITIVE ASPECTS OF CHRONIC ILLNESS IN CHILDREN — *Ronald T. Brown (Ed.) New York: Guilford Publications Inc., 1999, $42.00 (hard), 420 pages. (800) 365-7006.*

Violence decreasing in U.S. high schools

Researchers sought to measure trends in nonfatal violent behaviors among adolescents in the United States between 1991 and 1997. They used nationally represented data from the 1991, 1993, 1995 and 1997 Youth Risk Behavior Surveys to describe the percentage of students in grades nine through 12 who engaged in behaviors related to violence.

Overall response rates for each of the years of the survey were 68 percent, 70 percent, 60 percent and 69 percent, respectively. Logistic regression analyses were used to control for sex, grade and race or ethnicity. The main outcome measures of the study were self-reported weapon-carrying, physical fighting, fighting-related injuries, feeling unsafe and damaging or stealing property.

Between 1991 and 1997, the percentage of students who engaged in physical fighting decreased by 14 percent, from 42.5 percent to 36 percent, with the percentage of students who were injured in a physical fight decreasing by 20 percent, from 4.4 percent to 3.5 percent. The percentage of students who carried a weapon decreased by 30 percent, from 26.1$ to 18.3 percent and the percentage of students who engaged in physical fighting on school property decreased 9 percent from 16.2 percent to 14.8 percent. In addition, the percentage of students who carried a weapon on school property decreased 28 percent, from 11.8 percent to 8.5 percent.

"Declines in fighting and weapon carrying among U.S. adolescents between 1991 and 1997 are encouraging and consistent with declines in homicide, nonfatal victimization and school crime rates," the authors conclude.

Brener ND, Simon TR, Krug EG, et al.: Recent trends in violence-related behaviors among high school students in the United States. *Journal of the American Medical Association* 1999; 282:440-446. For reprints, contact Nancy D. Brener, Ph.D., Division of Adolescent and School Health, Centers for Disease Control and Prevention, Mailstop K-33, 4770 Buford Highway NE, Atlanta, GA 30341.

Resources

Dr. Koop's Web site offers health information to families

Former U.S. Surgeon General C. Everett Koop, M.D., sponsors a Web site on a variety of health topics ranging from family health to eating disorders to depression. A recent Web page on the site included news on the safety of drug ads, how to deal with depression, women and smoking, a definition of anorexia and bulimia and alternative treatments for muskuloskeletal pain.

Users may browse through a medical encyclopedia that explains many health topics such as handling migraine headaches, dealing with insomnia and getting proper nutrition. There also are more than 130 chat support groups on subjects that include mental health. A "personal insurance center" helps consumers choose a health insurance plan by comparing different types of health insurance.

Visit the Web site at www.drkoop.com

Keep Your Eye On ...

... principal shortages.

Schools nationwide are reporting a shortage of qualified applicants to fill vacancies for principals. Twenty school districts in Connecticut and several in New York City that were without principals a month before schools opened this fall, hired "interim acting" principals to oversee 144 schools. The problem reportedly is due to more principals reaching retirement age, fewer teachers wanting to take on leadership roles, expanding roles of principals into instructional leadership duties and inadequate salaries. Some school districts are resorting to using "headhunters," or corporate recruiters, to find qualified principals. (*School Board News*, volume 19, number 17, September 14, 1999.)

... SIDS classification.

Researchers from Sheffield University in England say it is possible that not all cases of sudden infant death syndrome (SIDS) are correctly classified. Some cases may be caused by intentional smothering. Using a new digital examination technique to look for signs of excessive blood in the lungs of infants who had died unexpectedly and suddenly, a group of pathologists found evidence of bleeding in more than 5 percent of total lung surface in 73 percent of infants thought to have suffered from SIDS, compared to 45 percent of infants suspected of suffering from intentional smothering. The more common technique is to examine lung tissue with a microscope. (*BBC Health*)

Risk behaviors that improved[1], 1991-1997

Injury-related behaviors	***1991***	***1993***	***1995***	***1997***
Never or rarely wore a bicycle helmet[2]	96.2	92.8	92.8	88.4
Carried a weapon[3]	26.1	22.1	20.0	18.3
Carried a gun[3]	N/A	7.9	7.6	5.9
Carried a weapon on school property[3]	N/A	11.8	9.8	8.5
Involved in a physical fight[4]	42.5	41.8	38.7	36.6
Involved in a physical fight on school property[4]	N/A	16.2	15.5	14.8
Seriously considered suicide[5]	29.0	24.1	24.1	20.5
Sexual behaviors				
Ever had sexual intercourse	54.1	53.0	53.1	48.4
Had four or more sexual partners	18.7	18.7	17.8	16.0
Used a condom at last sexual intercourse[6]	46.2	52.8	54.4	56.8
Had been taught about HIV/AIDS in school	83.3	86.1	86.3	91.5

[1] Significant linear change, $p < .05$.

[2] Among students who rode bicycles during the 12 months preceding the survey.

[3] On ≥ 1 of the 30 days preceding the survey.

[4] ≥ 1 time during the 12 months preceding the survey.

[5] During the 12 months preceding the survey.

[6] Among currently sexually active students.

N/A: data not collected

Source: CDC's 1991, 1993, 1995 and 1997 Youth Risk Behavior Surveys

... breastfeeding and HIV.

An infant's risk of becoming infected with HIV through breastfeeding is low, but it does occur, according to a recent study from the African nation of Malawi. The study, conducted by the National Institutes of Health and others, evaluated the timing of, risk factor for and HIV infection rate among breastfed infants of HIV-infected mothers. The researchers tested infants for HIV infection during visits to the postnatal care clinic of a large urban hospital. Only babies who tested negative for HIV at their first visit, six weeks after birth, were included in the study. Over the next two years, HIV tests on the babies revealed that 47 of the 672 infants in the study became infected during breastfeeding. The researchers conclude that breastfeeding recommendations for HIV-infected women in developing countries should carefully balance the risk of HIV transmission with the known nutritional and health benefits of breastfeeding. (*National Institute of Allergy and Infectious Diseases*. For more information, see the NIAID website at "http://www.niaid.nih.gov.")

PARENTING TEENS: LESSONS FROM THE TITANIC

BY MICHAEL H. POPKIN, PH.D.

Parenting teenagers at the end of the twentieth century is a lot like captaining the *Titanic*: the responsibility is awesome, the safety risks are enormous and the boat isn't as indestructible as it's been hyped. To make matters worse, your teen hasn't the life experience or perspective to tell an iceberg from an ice cube. No wonder so many parents enjoyed the movie version of *Titanic* — they can identify!

The good news is that, like most historical disasters, there are lessons that can be learned. And, as I've tried to teach parents for 25 years now, there is no substitute for someone else's experience. We don't have to make all the mistakes ourselves. (Unless, or course, you're betting that they'll spend $200 million making a movie out of your mistakes.) Here then are my top four parenting lessons from *Titanic*:

LESSON #1.

Teach your teens that they can't always get around it.

On April 10, 1912, the *Titanic* left England for New York on its maiden voyage. By all accounts, it was the safest ship ever built. Five days later it was lying in two huge pieces at the bottom of the Atlantic Ocean. Over 1500 people were dead as the unthinkable happened: the unsinkable ship had sunk. What exactly went wrong is still being debated. The movie *Titanic* presents the version in which the lookouts did not see the iceberg in time to do anything but hit it.

But while researching the infamous shipwreck for the revision of *Active Parenting of Teens* a year earlier, I came across another explanation. In this version the officer in charge had enough time to kill the engines and prevent the disaster. However, he mistakenly thought that he could save time by steering around the tip of the iceberg with the engines still running.

The problem is that about seven-eighths of an iceberg is under the water. The officer steered around the smaller portion of the iceberg that was visible, but he failed to consider the huge width of the underwater portion, which ripped through *Titanic's* hull like a can opener.

Many of the modern dangers that our teenagers face are like icebergs. Teens often think they know the risks of such ventures as drinking, drug use, sex and violence. They often mistakenly believe that they can steer around those risks and face challenges unharmed. However, like the officer on the *Titanic*, they often fail to see the bulk of danger — addiction, sexually transmitted diseases, pregnancy (and parenting), prison, even death. They may have plenty of positive qualities, but one mistake in judgement can be deadly. Part of our job as parents is to help teach them about the real risks...and slow down their engines.

Lesson #2.

Count the lifeboats before you get on the boat!

There is a scene in *Titanic* where the heroine is walking around the deck with the ship's architect and notices that there are too few lifeboats for all the passengers. "About half enough," he tells her. This is useful information, but not *after* you are already out to sea!

Just as it's important for you to help teach your teens the real risks involved with their behavior, it is also important for you to discuss a rescue plan for a worst-case scenario. What *should* your daughter do if a stranger tells her that you've been hurt and he has been sent to take her to the hospital?

Take time to talk to your children about various situations and effective ways of handling them. These conversations work best with a give and take of ideas by both of you — not a lecture series. Again, avoid coming off too judgmental if he or she disagrees with you about some things. Your main goal is to start your child thinking. He may see your wisdom better *after* the discussion than during. So, don't think you aren't making an impact even when you don't get total agreement.

Lesson #3.

Teach your teens the difference between hype and reality.

Children need to be aware that everything they see in movies, television and music lyrics is not accurate. Ads are designed to sell things. The Budweiser frogs are

(Continued, over ...)

cute, but we never see them binge drinking and dying from alcohol poisoning, getting date-raped or becoming alcoholics. Parents can help their teens see through the hype and make informed decisions.

Lesson #4.

Know when to change directions and when to stay the course.

Some people say, "If it ain't broke, don't fix it." Other people say, "This is boring!" The first group tends to be parents. The second group tends to be teenagers.

The captain of the *Titanic* chose to stay the course and paid a disastrous price. Changing directions and cutting the engines was certainly a better option. This is not to say that change merely for excitement's sake is a recipe for disaster. Childhood and particularly the teen years are a period where people want to test themselves and the need for excitement and adventure is high. We can help our teens find reasonably safe ways of having adventures through sports, outdoor activities and special interests.

We live in an era of rapid technological change. Many times our teens are more comfortable with this fact than we are. Adapting to change has always been the hallmark of the survivors of the species, any species. Yet humans are certainly not just any species. Just as parents can learn much about the changing world of tomorrow along with their children (and often *from* their children), they can also share the unchangeable truths of human history:

- ✓ Hard work and self-development will usually win out over opportunism and pure luck.
- ✓ Respect for self and others is better than the temporary lift of sarcasm and one-upsmanship.
- ✓ Cooperation beats rebellion; responsibility trumps blame and excuse-making in the long run.
- ✓ Justice and fair play are essential to living with others and feeling any satisfaction in one's victories.
- ✓ Love overcomes cynicism.

You have other truths to teach your children, truths that offer ballast on a stormy sea. Of course, this does not preclude your changing directions now and then or cutting your engines when an iceberg appears in front of you. After all, we don't have to repeat the mistakes of the *Titanic*.

Michael H. Popkin, Ph.D., is founder and president of Active Parenting Publishers. For a catalog containing his parenting books, go to www.activeparenting.com or call (800) 825-0060.

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up

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GLBT Youth

from page 1

gay." And as much relief as that sentiment often brings, mere affirmation is rarely enough. Sometimes it may even be distressing.

It takes time to understand each young person's world. Every individual brings a different constellation of: family history and culture, religion, race/ethnicity, class, age, gender, relational history, degrees of "being out (of the closet)," and amount of contact with the homosexual community.

Not every problem a GLBT student has is related to sexuality. Still, these youth face unique challenges to healthy adjustment in the universal adolescent realms of safety, belonging, self-worth, independence, closeness and good relationships, competence and self-awareness.

Harassment begins early

Homophobic name-calling starts in the early grades, where it is both the most common form of name-calling and the kind most feared by all schoolchildren. Harassment intensifies at pre-adolescence and often becomes physical. But schools are not the only dangerous places; intimidation and violence also occur on the playing field, on the streets and even in the home.

Many GLBT youth have no sense of belonging. Alienation from peers, family and church often leads to devastating isolation, the primary cause of suicidality. Though there is ample disagreement over gay teen suicide statistics, no one has challenged the frequency of depression and loneliness that are its precursors. After all, what is more important to an adolescent than fitting in somewhere? We cannot overlook the consequences of exclusion in Littleton, Colorado, where the "goth" misfits, reportedly tormented as "faggots," took others down with them in their suicidal rage.

Establishing self-worth is difficult for all stigmatized minorities. Unlike other minority youth, who most often share identities with their families and can usually depend on a safe and prideful haven from bigotry, gay youth rarely have gay families to come home to. Moreover, they often lack gay-friendly families. Even the high-achieving young homosexual can feel like a fraud if his or her status is contingent on concealing a dark secret.

Conservative attacks on the "self-esteem movement" claim that self-worth should not be encouraged in the "unworthy." What they ignore are the victims of prejudice whose self-esteem is diminished by wanton bombardment. These children deserve a compensatory boost to reach parity with their schoolmates. Once they have learned not to degrade themselves on the irrelevant bases of race, gender, or sexuality, they can move on to better criteria for judging people.

Achieving independence

Adolescents strive for independence, both practical and moral. But GLBT youth often have difficulty affirming that gay is good in a culture that tells them it is wrong, if not evil. Achieving day-to-day independence also is problematical. They undertake a journey that can jeopardize the material support of family and friends.

Some youth are actually thrown out of the home, fired from work, excommunicated from churches and dismissed from social organizations. Racial, ethnic and religious minority youth who come out as homosexual have a particular fear of cultural disinheritance as a consequence of asserting their sexuality independence.

Closeness and good relationships demand honesty. One cannot bond with family members or peers from whom one hides. Some GLBT youth immerse themselves in academics or hobbies to avoid intimacy. Some become jesters as a shield from personal disclosure; some minister fervently to others' needs to divert attention from their own. Those who cannot be open may seek surreptitious impersonal sex. When self-hatred and secrecy dictate these erotic practices, there is less capacity for deeper connections.

Gays and lesbians may have a hard time developing confidence in

Arthur Lipkin, Ed.D., is the author of *Understanding Homosexuality*, recently published by Westview Press. This text provides a foundation in gay/lesbian studies and offers models for equity, inclusion and school reform by bringing together topics related to homosexuality and education to make the gay, lesbian, bisexual and transgender experience part of a democratic multicultural vision.

Understanding Homosexuality will help teachers, administrators, counselors and policy-makers understand the significance of gay and lesbian issues in education; aid communication between gay/lesbian students and their families in the school community; promote the inclusion of gay and lesbian curricula in a range of disciplines; and further the healthy development of all students through reducing bigotry, self-hatred and violence.

Understanding Homosexuality is available in hardcover (558 pp.) for $69. The book can be ordered from Westview Press at (800) 386-5656.

their own agency and abilities. Regardless of whether they blame their own sexuality or fault others for being homophobic, the expectation of failure can be self-fulfilling. Psychological assault from family and others contributes to their giving up on themselves. Some gay and lesbian youth doubt their own efficacy because they have struggled in vain against their sexual desires. As adolescent girls, lesbians may feel doubly powerless and lose purposefulness. Schoolwork and attendance may suffer from their lack of confidence as well as fears of ridicule and attack. Then academic failure just reaffirms their sense of incompetence.

At their core, feelings of homosexual ineptitude relate to gender and sex-role stereotyping. Gay has become synonymous with male incompetence and immaturity. Lesbians who embrace "male competencies" are seen to be failures as women. Many gays and lesbians are disconcerted, particularly when they are young, by challenges to their gender identity. Some internalize the idea that their sexuality precludes them from claiming the stereotypical attributes and perfecting the conventional skills of their gender.

Denial inhibits self-awareness

Homosexual youth are deterred from self-awareness by the twin ogres of denial and admonishment. Beset with fear and abetted by a culture that warns against and denies homosexuality, they sometimes are deluded into thinking that they can choose to be someone else. GLBT adolescents have feelings that, once acknowledged, can explode their private and public identities. Inner conflict builds as they grapple with a new self and its certain social stigmatization.

Teachers, counselors and therapists therefore must be well informed about sexual identity development and about homosexual adjustment and counseling issues. We must be able to help troubled *GLBT* youth rid themselves of any internalized homophobia that interferes with their growth and cripples their resilience. As a precondition we should examine the heterosexist (or internalized homophobic) biases in our own professional practice and interpersonal relationships. ■

Arthur Lipkin is an instructor at the Harvard Graduate School of Education and founder of the Gay and Lesbian School Issues Project. He is currently directing the Safe Colleges Program of the Governor's Commission on Gay and Lesbian Youth. He can be reached at arthur_lipkin@gsc.harvard.edu.

For more on GLBT youth, see Dr. Lipkin's *Guest Commentary* on page 8.

Early Experiences

from page 1

information and energy with other systems. Suddenly the amount of information and/or energy coming in overwhelms the system we're looking at and it falls apart into apparently random bits. Indeed, after the "bang" it looks like chaos.

Suppose now that the level of energy or information that destroyed the original system continues to be present. What happens is that a new system comes into being—and all we can tell about the new system is that it was not predictable from the old one, and that it is more complex than its predecessor. This scenario plays itself out across all kinds of dynamic and adaptive systems—galaxies and quarks, ant hills and forests, economies and societies.

Further, it turns out that the new systems that emerge from "chaos" are not formed randomly; and that we could describe how the new complex adaptive system came about from a fairly simple set of rules interacting with the setting in which it occurs. There is hardly a more elegant example of an emerging complex adaptive system than a healthy human infant.

I have here presented a wildly oversimplified description of a whole new branch of scientific inquiry variously known as Complexity Theory and as Dynamic Systems Theory.

It started in theoretical physics where most new scientific theories seem to begin, and has, over the last two decades, inspired new research and new understandings across all of the sciences, including psychology (see Suggested Reading, below, for recent publications applying these concepts to studies of children.

We can illustrate how these ideas apply to understanding the emergence of the adaptive capacities we label as intelligence, personality and social skills by using the same variables applied to other adaptive systems. Let me describe such emergence in these terms.

We can describe the early years of life as the beginnings of the construction of the individual's complex adaptive system, recognizing that this construction and reconstruction proceeds throughout the life of the individual.

The earliest experiences are the most important, for it is these experiences that are used to construct the architecture of the brain/mind, and so provide the ways, the networks and "places" in which subsequent experiences are stored, and influence how readily and how flexibly they are available for the acquisition, retention, accession, differentiation and integration of later experiences.

Building the feedback loop

To be successful in interacting with the outside world and to meet the demands of the body itself, the individual must first of all be able to aggregate experiences, build classification systems in which to store them, and be able to label the experiences, the aggregations and the classifications. The classifications have to be of sorts that permit comparisons, larger and smaller classes and permit both inductive and deductive utilization of the experiences they represent. These then permit the construction of internal models that allow the individual to anticipate future events and the next steps in a process.

These classification systems and the internal models permit the construction of nonlinear feedback loops that serve several critical functions, including the modification of behaviors and anticipations of the effects of acting on these anticipations, thus permitting new learning and the fine-tuning of responses.

An essential type of feedback loop enables the individual to focus on those aspects of interaction that have immediate significance. Such stimuli arouse emotional signals that require foci. Indeed, the feedback loops between emotional signaling and cognitive appraisal become major tools in the cognitive growth and style of most mobile organisms.

At the same time, the dependence on anticipation based on internal models in an ever-changing world means that all anticipations are accompanied by some amount of anxiety. This anxiety can have the positive effect of focussing attention and increasing alertness, or the negative effect of overwhelming the ability to use the information provided by the feedback loops.

Since new situations require the individual to draw upon an inventory of internal models, the more diverse the individual's experience, both in content and in sensory connections, the more likely the person can cope with the new situation. Wide diversity permits the individual to compensate when the usual solutions to a problem do not work.

Past experience can be used to solve new problems to the extent that the individual can deconstruct past experiences and rearrange the components so as to test hypotheses as to how to deal with the new experience. Feedback keeps us appraised of how well we are proceeding in using this way to deal with novel problems.

Acquiring personality

Repetition of certain sequences of stimuli and their consequences can be conceptualized as attractors. These sets of stable sequences create a characteristic pattern or flow in processing experience, and style of dealing with energy, information and problems. The style is a large part of what we call "personality." It includes multipliers, which highlight or amplify certain kinds of input, and recycling properties that permit the deconstruction of experiences to solve new problems.

This view of growth is based upon a series of premises that can be only listed here. First of all, it assumes that the growth of knowing is continuous, aggregative and individualized. Change and emergence of new configurations are continuous with experience, interactions with others and with other aspects of the environments. This interaction is nonlinear; external stimuli provoke reactions that in turn affect the source of and nature of the external stimulus.

The individual is neither a passive recipient of influence nor a powerful creator of change, but is part of the larger dynamic system in which the individual lives. The so-called stages of development, whether promulgated by Freud or Piaget or others, are simply artifactual reflections of the general conditions of growth in a given culture at a given time. The subgroup differences ascribed to ethnicity similarly reflect local variations in the typical environment.

This view of how individuality and mind emerge requires that we largely abandon our prevalent models and measures of children, and re-design the curricula and systems of stimuli we provide children from birth onward. ■

Irving Lazar is a member of the external faculty at the Santa Fe Institute and Professor Emeritus at Cornell University.

Suggested Reading on "complex-mind theories"

Barton, S: Chaos, Self-organization, and psychology. *American Psychologist.* January 1994, pp. 5-14.

Fischer, KW and Bidell, TR: Dynamic Development of Psychological Structures in Action and Thought. In: Damon, W and Lerner, RM. Handbook of Child Psychology. Vol. 1, New York: John Wiley & Sons. 1998, pp. 467-561.

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Masterpasqua, F and Perna PA (eds): The Psychological Meaning of Chaos. Washington, DC: American Psychological Association, 1997.

Smith LB, Thelen E (eds): A Dynamic Systems Approach to Development. Cambridge, Mass: MIT Press, 1993.

Thelen, E and Smith LB: A Dynamic Systems Approach to the Development of Cognition and Action. Cambridge, Mass: MIT Press, 1994.

Guest Commentary

GLBT youth need affirmations to balance cautions

By Arthur Lipkin, Ed.D.

In the past decade, following the publication of Gil Herdt's *Gay and Lesbian Youth*, there has been a barrage of information about gay, lesbian, bisexual and transgender (GLBT) youth in academic and popular writing. This is a most welcome development, as these young people and their needs were too long ignored. Yet at the same time, the many details of their plight have imposed a burden on those of us who work in schools to combat the image of "queer youth" as a repository of risk behaviors, a pathological and pathetic bunch. *

There is danger for all young people in hearing only the horror stories. Those who are GLBT or who are in the process of discovery need support and encouragement. Though they, like all adolescents, should be counseled toward circumspection, they must also be affirmed in envisioning a happy and productive future. The gay world into which they are emerging need not be *The Well of Loneliness* or *The Boys in the Band*.

> *Despite the theories of psychiatrist Charles Socarides, there is no evidence to suggest that homosexuals are constitutionally disposed toward psychological illness or risk-taking.*

Likewise, heterosexual youth must be guided toward understanding and empathy, not merely sympathy, for their homosexual classmates.

On the other hand, the common recitation of grim statistics has helped our cause by generating public awareness and support for government funding of many worthy programs. In Massachusetts, for example, the budget of the Safe Schools for Gay and Lesbian Students programs for schools and colleges is now $1.5 million. Although that level of support is rare, incremental progress is notable in many states.

The litany of ills that has generated such largess is by now familiar — harassment, physical attack, low self-esteem, suicidality, substance abuse, eating disorders, HIV and pregnancy. Massachusetts Youth Risk Behavior Surveys in 1995 and 1997 highlight significant risk to GLBT youth through

- Having property damaged or stolen, being in a fight at school, being in any fight requiring medical treatment, being threatened with and/or carrying a weapon at school and feeling unsafe traveling to and from school.
- Seriously considering, planning, or attempting suicide.
- Using alcohol, marijuana, cocaine and tobacco.
- Having sex voluntarily or unwillingly, having multiple partners, becoming pregnant or causing a pregnancy.

None of these risks should be dismissed or minimized, yet progressive activists must also take care to put them into context. First, they are not the inevitable consequences of a homosexual identity. Many GLBT youth are thriving and many are models of resilience. It is still not clear what factors account for their remaining relatively unscathed.

Second, homophobia and mistreatment often provoke psychological problems and destructive behaviors. Despite the theories of psychiatrist Charles Socarides, there is no evidence to suggest that homosexuals are constitutionally disposed toward psychological illness or risk-taking. Indeed greater risk behavior is associated with greater gender atypicality and hence victimization. Seeming to be gay, intentional or not, can provoke the harassment that may lead to pathology.

As we work to eliminate homophobia and to spotlight the resiliency of many GLBT youth, we cannot of course abandon those who are struggling or already damaged. Yet we must also take care not to reinforce stigma and hostility by accenting the risks and forgetting the affirmations of gay and lesbian life.

For more on GLBT youth, see Dr. Lipkin's article on page 1.

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* Note: Although transgender people are a distinct group their transgression of conventional gender norms evokes similar hostility and many common risks to those of bisexuals and homosexuals.

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